Calderdale and Huddersfield
NHS Foundation Trust

NHS

Annual Report & Accounts

2011/12

Your Care
Our Concern

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Calderdale and Huddersfield NHS Foundation Trust

Annual Report & Accounts 2011/12

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Chairman's Statement

Without a doubt, this is a time of tremendous change in the NHS both here at our Trust and nationally.

In addition to my own appointment last July we appointed our new Chief Executive, Owen Williams, in February; the first change at the top for 15 years. We said a very fond farewell to Diane Whittingham at the end of March who had been at the helm for such a long and successful period at our Trust.

We also welcomed Consultant Surgeon David Wise as our new Medical Director and Keith Griffiths joined us from Liverpool as Director of Finance. They replaced Yvette Oade and Mark Brearley, respectively, who both moved onto new challenges at other Trusts during the year. Board colleague Carol Clark (deputy chair) also left us in November after contributing so much over the years and, to complete the Board changes, we appointed Peter Roberts, David Anderson and Jan Wilson as new non-executive directors.

I would like to thank all the former colleagues for their work, enthusiasm and dedication over the years and also pledge the commitment of the "new-look" senior team to continue to develop and strengthen this Trust for the challenges of the future.

The beginning of the year also saw 500 community staff from Calderdale join us as part of the Transforming Community Services programme. This year has been about integrating them into our organisational structure and the planning of the streamlining/improvement of services that this will enable.

The one certainty about the Trust's future is that it is going to involve very great change starting right here right now.

The Health and Social Care Bill has provoked a massive debate about healthcare in all quarters across the country and whilst, quite rightly, it has been subject to challenge, it is also widely agreed the NHS does need to change to be best able to meet the needs of its patients.

And locally that process is very much underway. Healthcare professionals across Calderdale and Huddersfield have been meeting throughout the year to look again at the shape of local services to refresh them and make them more tailored to our patients' needs. Close team working between hospitals, our community staff and local authority staff is at the very heart of this process and continues apace.

For me, in my first year as Chairman, it has been a year of meeting people in all the divisions at the Trust and learning more and more every day about just how the NHS locally succeeds in delivering the enviable care it does.

It became pretty obvious, pretty quickly, that it is our staff – every single one of the 6,300 – who make it all possible. At the staff annual Celebrating Success awards amazing stories of sheer dedication and inspiration are given the spotlight they deserve. Yet I have realised that day in day out it is their professionalism and care that continues to make the Trust the quality healthcare deliverer it is for our patients.

So, a big thank-you to all and I also include our volunteers, League of Friends supporters and our Membership Council, who support our Board in making the key decisions to make sure patients get the right care in the right setting.

My biggest thank-you I leave until the end and that goes to Diane Whittingham. Our Chief Executive for 15 years steered this Trust through incredible changes and yet we maintained our reputation and position within the NHS as one of the recognised leaders – always moving forward, always looking to improve – and with a caring heart at all times with our patients at the very centre of what we do.

She has been an enormous help to me personally as a mentor and guide as I began to take over the role of Chairman of the Trust and I hope to be able to build on and continue her tremendous legacy.

Andrew Haigh
Chairman

Chief Executive's Statement

This will be my final statement for the annual report as I will be leaving the Trust at the end of March 2012. I have had both the pleasure and the privilege to spend over 30 years working in the NHS and 15 of those years have been spent in Calderdale and Huddersfield. During this time I have seen the Trust grow, develop and significantly improve the services we deliver to our patients. We have embarked on two major service reconfigurations, merged organisations, achieved Foundation Trust status and due to our consistent high performance were named the 'Acute Healthcare Organisation of the Year' in 2010. It has been a period of significant change and we have seen our services transform and our outcomes substantially improve.

Given this is my last report I wanted to not only share our in-year achievements but I also wanted to tell you more about the people who deliver our services, the staff you often see and those who work hard behind the scenes to ensure that our services run as smoothly as they can. The Trust is one of the largest employers in the area, providing jobs for over 6,000 people. We have a significant impact on the health and wealth of the local area and we take our responsibilities very seriously. Many of our staff originate from the local area but we employ many other professionals who choose to live locally and raise their families here. Any organisation is only as good as the people it employs and we have some of the best. At every level we have people who go the extra mile, they work tirelessly to provide excellent services for our patients and they care about what they do. The Trust has many unsung heroes, people whose kindness and consideration for others shines through, who put patient needs before anything else and who bring a smile to everyones face. These are the people I admire and the ones I will never forget.

Two years ago I signed off my statement saying that "we cannot afford to stand still if we wish to stay strong in a tough environment". This still applies and we have made great progress in the last year. 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.

Some of our achievements this past year are as follows:

- The opening of our new surgical assessment unit at Huddersfield Royal Infirmary (HRI) providing a better, smoother delivery of outpatient care for our patients.
- More than 200 patients are now having heart stents fitted at Calderdale Royal Hospital (CRH) after we brought the service back from Leeds.
- A new "greener" boiler system at HRI helping us to be good neighbours and to reduce our carbon footprint.
- The unveiling of our plans for the development of the Acre Mill site at Huddersfield, jointly with partners Henry Boot Developments Ltd, to become a modern, state-of-the-art centre for many of our patient services.
- Our stroke care, being judged among the very best in the region in a report from the Royal College of Physicians.
- A new Single Point of Access (SPA) was set up in Calderdale bringing together hospital, community and local authority staff to provide stream-lined social care.

- Dialysis patients moving into a bright new modern unit at HRI in a joint project with partners at Leeds Teaching Hospitals, replacing the old one at St Luke's.
- Surgery training started at HRI making us one of the few trusts in the country accredited by the Royal College of Surgeons to deliver this specialism.

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. We constantly receive feedback on our services and you tell 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.

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 strong position to face the challenges to come. I hope that our hospitals and services thrive, not just survive, through these changes and I have no doubt that my successor Owen Williams, with the support of the Board of Directors and staff, will keep the Trust moving forward. There is no doubt that further changes to our services will be necessary and I hope that you will seek to understand the drivers that lead to change and support the professionals who are trying their best to transform our services. There is a dedicated and professional workforce across Calderdale and Huddersfield who are doing all they can to ensure that our services stay local, remain strong and are there for you and your family when you need them.

I thank them and you for all of your support, friendship and kindness and offer my best wishes for the future.

Diane Whittingham
Chief Executive

Directors' Report

History

2011 saw the 10th anniversary of this Trust delivering healthcare to the people of Calderdale and Huddersfield. In that time we have been Health Service Journal's Acute Organisation of the Year in 2010 and achieved many top ratings at national level keeping us at the forefront of quality healthcare in this country.

It was also a key year in our Trust's development as we were joined by 500 staff from NHS Calderdale bringing our staff numbers to more than 6,000. This marked the start of a new, extra direction in the way our services at the Trust are delivered, based on close ties between hospital and community. Providing care in our communities and supporting people to manage their long-term conditions in their own homes will be a key priority in the years ahead for our Trust. At the same time we shall continue to deliver hospital-based patient-focused quality healthcare to our local population.

As a Foundation Trust - a status gained in 2006 - we have had the freedom to develop and invest in our services to make sure they are tailored to the best needs of our local patients. Amongst our plans in the last year was the start of developing the Acre Mill site in Huddersfield to provide a state-of-the-art outpatients unit and we also pushed ahead with our move into the Broad Street development in Halifax. This further strengthens our role right in the heart of the community as we have already done in the Upper Valley as we continue to expand our services at the Todmorden Health Centre.

We also welcomed consultant orthopaedic surgeon David Wise as our new medical director confirming clinicians and consultants at the heart of our organisation and making sure quality healthcare is at the heart of all decisions into the future.

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 120,000 men, women and children were cared for as inpatients (stayed at least one night) or day cases and more than 409,000 people attended our outpatient clinics. Our A&E departments at both hospitals cared for more than 138,000 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 us on April 1 2011 from NHS Calderdale – the primary care trust (PCT) which used to provide these services. From April 2011 to March 2012 some 175,000 adult service and 90,000 children service contacts were provided by our community teams.

Our vision and values

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

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

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

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

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

"We shall continue to deliver hospital-based patient-focused quality healthcare to our local population."

Stakeholder relations

Diane Whittingham receives the award from Jason Harries from CHKS

The Calderdale and Huddersfield NHS Foundation Trust (CHFT) has been named one of the CHKS 40 Top Hospitals for the second year running. The accolade is awarded to the 40 top-performing CHKS client trusts and is based on the evaluation of 21 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. Strong partnership working is one of the key elements that allows CHFT to perform well and consistently achieve high profile awards such as this.

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 PCT Cluster, the emerging Clinical Commissioning Groups 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 2011/12 the Trust worked with the local health economy and particularly GPs to improve pathways in areas such as urgent care, stroke, 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.

Our Trust is working with partners to ensure all services will continue to be delivered safely and meet the demand created by our population as it ages.

In 2011 we integrated adult and children's services from the provider arm of NHS Calderdale into our Medicine division and Children, Women's and Families Services respectively. Both divisions have now restructured to ensure patients receive maximum benefit from the joining of these services. 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.

Community staff in Halifax

In 2011 we formed a new joint venture partnership company with Henry Boot Developments Limited. The new company has been 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.

Acre Mill site

We continue to develop specialist services with the support of the Yorkshire and Humber Specialist Commissioning Group. In 2011 CHFT 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. A 58-year-old Huddersfield man became the first person to receive treatment at Calderdale Royal Hospital on August 1 – and went home the next day.

PCI team staff

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

We are also working with Bradford to develop the Plastic Surgery service and in 2012 we appointed a consultant oncoplastic breast surgeon, Alison Waterworth. Alison joins our team of surgeons, oncologists, breast care nurses, clinical nurse specialists and radiologists in a brand new post. Oncoplastic breast surgery combines the surgical removal of breast cancer with plastic surgery techniques to achieve the best possible shape and appearance.

Alison Waterworth second from the right together with our breast care staff

In partnership with the tertiary service at Leeds, Huddersfield kidney dialysis patients are now receiving their treatment in a brand new £1.5 million unit at Huddersfield Royal Infirmary. The facility is run by Leeds Teaching Hospitals NHS Trust, which provides specialist renal services to patients across West Yorkshire.

Renal Unit staff at Huddersfield

The Trust was one of only four sites nationally chosen to take part in an ambitious three-year programme, funded by NESTA (National Endowment for Science, Technology and the Arts), called People Powered Health. Since the programme was launched in 2011, volunteers and Trust clinical staff have been working with groups of patients to manage their own care, 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.

The Trust has seen a change in three key senior management posts. A new chairman has been appointed by our Trust. Andrew Haigh, 58, has been a non-executive on the board since December 2010 and succeeds late chairman Sukhdev Sharma who sadly died in April 2011. The Trust has appointed Owen Williams as our new Chief Executive. Owen joined our Trust in mid May. He has been Chief Executive of Calderdale Council so is familiar with many of the communities we serve and our organisation. Mr David Wise has been appointed the medical director of our Trust. Mr Wise, who was previously divisional Director of Surgery and Anaesthetics, formally took up the role on October 3. Keith Griffiths replaced Mark Brearley as Finance Director in July 2011.

Patient Care

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 successfully register under the new statutory requirements of the Care Quality Commission.

The lymphoedema team won the British Journal of Nursing (BJN) Lymphoedema Nursing Award 2011 in London hosted by TV doctor Christian Jessen and the former Chief Nursing Officer Dame Christine Beasley. Their service redesign

Lymphoedema team

to deliver patient care in community settings won the BJN lymphoedema award from a shortlist of three other projects. The judges hailed the project for showing initiative and hard work. The team runs clinics in hospital but it was the pioneering outreach clinics in the community at Brighouse, Laura Mitchell and Todmorden health centres and at Kirkwood Hospice, which won the award. The clinics help sufferers to live normal lives by reducing the swelling, controlling the condition with compression garments, skin care advice and exercise.

The midwives at our Trust were runners-up in the Team of the Year at the British Journal of Midwives annual awards. Our account of team working and how we have developed and improved maternity services since reconfiguration came second out of a final shortlist of five.

Trying out the new check-in system

CHFT is at the forefront of patient care with a new electronic check-in system at both Calderdale Royal Hospital and Huddersfield Royal Infirmary. The new touch-screen systems should end waits and queues for checking-in for outpatient appointments at both hospitals. They are operated by simply scanning the appointment letters, which carry a barcode, in a process which takes just seconds. They can also be operated by simple-to-use touch screen directions. Reception staff will continue to help out when necessary and the new system means they should have more time to sort out follow-up appointments for patients. Digital check-ins are a relatively new development at hospitals and the Trust is amongst the first to install them. Many GP practices already use them.

June 2011 also saw the opening of the new £380,000 surgical outpatient unit at Huddersfield Royal Infirmary.

Successful midwife team

Staff nurse Anne Smith snips the ribbon at the opening

Directors' Report

A new £120,000 unit for women with urgent and emergency gynaecological conditions has opened at Calderdale Royal Hospital. The one-stop decision unit, on ward 4, is treating up to 100 patients per week. Specialist staff provide speedy assessments and care for women with a range of conditions. The patients are given blood tests, ultra-sound scans and seen by specialist nurses and doctors before a decision is made on treatment. Before it opened women with urgent gynaecological problems would have had to access care via the A&E department.

The team on the new Gynaecology unit

Our Trust is now providing more hospital services at Todmorden Health Centre. A monthly rheumatology clinic started in February headed by a consultant rheumatologist. Being able to care for our patients closer to their homes in their communities is a very important part of the way we are looking to deliver healthcare in the future.

Staff tucked into food served to our patients as part of a sampling test for Nutrition and Hydration Week. The week was organised by the National Patient Safety Agency and Patient Safety First to focus on the importance of food and hydration.

Food tasting at Huddersfield Royal Infirmary

Patients' food at both Calderdale Royal Hospital and Huddersfield Royal Infirmary has been rated as excellent in the latest survey by the National Patient Safety Agency for the second year in a row. The rating was awarded after being inspected by the Patient Environment Action Team (PEAT), which is made up of patient representatives alongside staff from the Trust. The PEAT assessment examines standards in three main areas at each site:

- Environment: cleanliness, decoration, linen, furniture and state of repair.
- Food: quality of food and its nutritional value.
- Privacy and Dignity: the quality of sleeping accommodation as well as toilet/bathroom facilities.

In all categories both hospitals were rated as either good or excellent.

Quicker interventions, along with a six step plan, for sepsis are helping to save the lives of patients in A&E. New procedures, which will be spread to other parts of our hospitals, are helping to improve the outcomes for patients suffering from sepsis. Sepsis is defined as an overwhelming infection which can lead to organ failure and death if it is not treated properly. It kills more people than lung cancer and is frequently seen in A&E coming in a number of forms such as urine, chest or wound infections. It is particularly common in the elderly. Using a national sepsis framework, six steps have been put in place for patients; these include fluids, antibiotics, oxygen, blood cultures, blood tests and urine testing, known as Sepsis Six.

The virtual ward team

An innovative new virtual ward scheme, adapted from a Toronto model, has been launched in Calderdale and Huddersfield. The scheme, spearheaded by the Trust in partnership with NHS Kirklees, NHS Calderdale, Locala and South West Yorkshire Partnership NHS Foundation Trust, was launched on December 1 2011 as a pilot study. The aim of the scheme is to reduce hospital readmissions to the Huddersfield Royal Infirmary and Calderdale Royal Hospital by identifying patients who are at high risk of readmission and managing them more effectively in the community. The scheme is run by a small team of community matrons, dementia matron, nurses, community pharmacists and falls practitioners. It uses the systems, staffing and daily routine of a hospital ward to

provide case management in the community. Patients are identified using a risk assessment tool, which takes into account local healthcare data around readmissions. Those patients identified as high risk are allocated a case manager and managed for 30 days post-discharge. All patients are fully assessed and a care plan put in place on the first visit.

Dementia patients are being given specialist care as part of a Trust-wide scheme to improve treatment for those with the condition. The butterfly scheme allows staff to identify patients with dementia and provide them with the specialist care they need. Patients with dementia have specific needs, for example nursing staff may have to explain to them who they are and where they are each time they approach. They may also have sleeping routines or food preferences they are not able to communicate to staff. The butterfly scheme helps overcome these difficulties making it much better for staff as well as patients. The system works by a butterfly symbol being placed on the bed of the patient. It is also highlighted in their care records, appointment records and on patient flow boards. As well as nursing staff being given training, cleaning staff and porters who have contact with the patients are also being trained. People have the option to go on the scheme. Currently, it is the relative or carer who will usually make this decision. A new process to be introduced in Kirklees will enable the patient to make this choice when they are first diagnosed. It is currently being used in our Medical Assessment Unit and short stay wards on both sites, as well as other wards.

Nurse consultant for older people Barbara Schofield

Patients who have suffered a broken hip and need surgery get some of the best care in the country from staff at our Trust, according to a national hospital guide. The Dr Foster Hospital Guide, which highlights good practice in Trusts across the NHS, singled out our Trust as among the leading care deliverers in neck of femur (NoF) treatment. Our team of specialists made up of doctors, nurses, therapists and managers, has worked on improving the timing of the (NoF) care from A&E, through to the ward and into surgery and aftercare. The timing is crucial to how well a patient recovers after surgery. To have the best recovery our patients – many of whom are elderly – need to be operated on as soon as possible, so we aim for the surgery to be carried out within 24 - 36 hours of our patients coming into the A&E department. All aspects of patients' care are assessed pre-surgery including hydration, pain relief, and underlying medical conditions. The Trust is in the process of appointing an orthogeriatrician to add further skills to the multi disciplinary team supporting this cohort of patients. Overall the performance reported for the Trust in this hospital guide reflects the good service provided by the Trust to our local population.

Neck of femur team

Our Trust's occupational health team is the first nationally to be given the second stage practice development accreditation. Staff showcased the work of their department as part of a bid to achieve the status last month. Assessors from Leeds University and South West Yorkshire Partnership Foundation Trust visited Calderdale Royal Hospital in September as part of the assessment. They listened to presentations from staff before looking closely at the work and culture of the department. The staff were given praise for team work, being able to accept challenges and think on their feet. They were also given recognition for innovation, motivation and passion for what they do. The report also said:

"The occupational health department team is both a fantastic advertisement for the wider trust and a true inspiration for those of us from outside the organisation who have been privileged to have seen the progress that has been made over the past couple of years."

Occupational health team

Directors' Report

Stroke care team at Calderdale Royal Hospital

The stroke care offered by our Trust is the best in West Yorkshire – and amongst the best in the country, according to a new report. The Royal College of Physicians (RCP) report revealed our Trust achieved the highest rating locally in a range of key areas of care, including how long a patient spent on a specialised stroke care unit, how quickly they were initially admitted to that unit and how many were admitted to the unit within four hours. Receiving care on a specialised stroke unit is recognised as the best way to achieve the best outcomes for our patients. There have been several developments in stroke services in 2011/12. A thrombolysis service has been introduced for the urgent treatment of acute stroke. Nine patients have benefited from this life changing treatment. Although the service is currently offered in the daytime we are developing the provision of a 24 hours a day 7 days a week rota to provide this service in partnership with colleagues at three other local acute trusts. Similarly trans-ischaemic attack clinics (TIA) have been set up for the urgent (within 24 hours) diagnosis and treatment of patients suffering a suspected TIA. These are provided Monday-Friday. With the appointment of a new consultant in June 2012 the Trust will be able to roll these out to weekends too.

Head of stroke care Dr Irfan Shakir

New joint care plans for people who have suffered a stroke are being piloted and aim to make sure patients are fully involved in planning their care. The plans, being piloted on the acute stroke unit, the stroke rehabilitation wards and in community rehabilitation and care teams, have been developed through consultation with doctors, nurses, therapists and social services in line with national best practice. The packs contain information for patients about the stroke they have suffered and how they can reduce the risk of a further stroke. They outline the tests they have had and what the results mean, as well as details that have been agreed with the patient for their rehabilitation, including any personal goals. The patients take their joint care plan home with them and continue to use it as an information resource and to plan their on-going rehabilitation.

The early supported discharge service for stroke patients was introduced in October 2011. It provides patients with a range of services in their own homes and builds on plans put in place. Therapy available includes physiotherapy, occupational therapy, speech and language therapy, dietetic advice as well as podiatry and orthotics support. The development is in keeping with the National Stroke Strategy and the Royal College of Physicians Stroke guidelines and will meet the Stroke Quality performance target, which suggests early supported discharge should be used as an alternative to long inpatient stays for patients.

Thorough cleaning helps to keep C diff at bay

Cases of Clostridium difficile (C diff) dropped again at CHFT. The latest data from NHS Yorkshire and the Humber Single Assurance Accountability Process (SAAP) places our Trust as the top acute trust in the region for low numbers of Clostridium difficile.

"Our Trust achieved the highest rating locally in a range of key areas of care."

Intensive care staff at Huddersfield Royal Infirmary are celebrating after achieving 300 days without a ventilated acquired pneumonia. Ventilator associated pneumonia or VAP is the second most common hospital-acquired infection and preventing it can be difficult. The elements of the ventilator care bundle are embedded into daily practice and compliance with all the elements of the bundle on all ventilated patients has been the key to the success in reducing VAP and improving patient safety.

A new system of courtesy rounds is being tested on ward 3 at Huddersfield Royal Infirmary. This is to improve communication with patients, making sure they fully understand all aspects of their care, their medication and their discharge. They are being held after the afternoon handover with a senior nurse making sure she has an extended one-to-one chat with all the patients and their relatives. Patients are also invited to ask any further questions to put their minds at rest during their stay with us.

Courtesy rounds on ward 3

Up to 300 patients a year who have previously had to travel to Leeds for specialist angina tests can now have them closer to home. We now have a team at Huddersfield Royal Infirmary who can image the blood flow to the heart via radioactive tracer medicine (myocardial perfusion scintigraphy or MPS). This replaces the traditional exercise testing for angina sufferers – where patients were put through their paces on a treadmill - and was only previously available in Leeds. These tests enable us to look inside the patient with suspected angina. They give us a much more accurate assessment and a full picture of the blood flow to the heart. It is more involved but it is better for the patients as doctors get more vital information upon which they can base their future treatment.

Dr Heshan Panditaratne from the angina testing team

Endoscopy team at Huddersfield Royal Infirmary

Our two new endoscopy units are off to a flying start, gaining full accreditation within weeks of opening. Inspectors came to look around the units at both hospitals and awarded the accreditation for five years, highlighting areas of care which are first class. In their final report the assessors said the sites should be congratulated on being patient focused, innovative and for delivering quality standards. The multi-million pound units are the most modern facilities of their type in the country. The assessors singled out the following for the two new units, in a glowing summary:

- Outstanding cross-site leadership and teamwork.
- Outstanding and sustainable approach to quality standards and governance.
- Endoscopy unit patient-centred design and quality.
- Excellent patient-centred service.
- Unique alignment of Bowel Cancer Screening standards with the whole endoscopy service.
- Supportive culture to provide training to all staff, medical, nursing and administrative.
- Very good audit systems and governance.
- Sustainable approach to waiting list and demand management.
- Innovation such as introduction of pre-assessment process and protected time for nurse training.

Mortality rates for colorectal cancer patients at our Trust are amongst the lowest in the country. According to figures released by the National Cancer Intelligence Network (NCIN), patients undergoing surgery for colorectal cancer in our Trust have a significantly lower 30-day post-operative mortality compared with the national average. We are one of only two Trusts in the Yorkshire Cancer Network to have such low mortality rates. Each year, details of patients undergoing operations for bowel cancer are submitted to the National Bowel Cancer Audit Project (NBOCAP) as part of an ongoing national audit.

Supporting people at home and in the community

In April we welcomed health visitors, district nurses, school nurses and specialist nurses from NHS Calderdale into our organisation.

This is an exciting development and means that our patients will receive high quality, seamless care through the most appropriate mix of hospital and community care.

We have also worked closely with our colleagues at Calderdale Council to improve outcomes for our patients, and make better use of our staff time and financial resources.

In November the new Single Point of Access (SPA) was launched in Calderdale. The new service began following the successful integration of a range of services, including Rapid Response, Community Rehabilitation, Falls Prevention and the Calderdale Council Reablement teams. People have reported high levels of satisfaction with the new service.

Service user Alison Alexander, of Halifax, said:

"Thank you so much for the invaluable advice and information, and for the help given to assist my parents."

The Trust is continuing to work closely with Calderdale Council to look at how we can redesign, improve and deliver more integrated health and social care services against the backdrop of an ageing population and a challenging economic climate.

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.

At the end of October 2011, we integrated our Patients Advice and Liaison Service (PALS) and Complaints Service to provide a single combined 'Patient Advice and Complaints Service' with a new freephone number 0800 013 0018.

We can provide information and advice; a contact point for compliments and feedback and the management of concerns and complaints.

Staff Relations

The Trust employs more than 6,000 staff working in a variety of roles and settings and engagement with employees takes place in a number of ways at an organisation-wide and more local level.

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 are 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.

Strategy to Save Jobs

In 2010/11 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 high 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.

A key feature of the work agenda for the Trust's Strategy to Save Jobs over the last 12 months has been the design and implementation of probationary periods for new appointments. This policy was introduced on April 1 2011 and its purpose is to support the Trust's requirement for the recruitment, development and retention of high quality staff. All new staff are now required to undergo a probationary period to determine their suitability for the posts they are occupying. Evidence suggests that the use of probationary periods increases the probability that new employees will succeed in their employment.

Employment of people with a disability

The Trust has due regard to the General Duties of the Equality Act 2010 as follows:

- Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The duties are relevant to the protected characteristics listed below:

- Age
- Disability
- Race
- Sex
- Sexual orientation
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Religion or belief

The Trust is committed to advancing equality of opportunity for staff with protected characteristics. This includes equal opportunity for training, promotion and career development.

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

The Trust tackles direct and indirect discrimination against staff of all protected characteristics, and minimises the disadvantages suffered by staff with a disability through provision of workplace aids and adaptation. This is demonstrated by the Positive about Disabled People 'two ticks' award, which the Trust has retained for over 10 years.

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 2011/12 the Trust's sickness absence rate was 4%.

The Trust recognises that the staff are the most important asset in service provision. If their health and welfare affect attendance at work then there will be an effect on the Trust's ability to provide the required services.

High rates of absenteeism are costly not only from an economic point of view but also because of the effects on morale for other staff and the potential loss of continuity of patient care. The Trust has a policy which supports the regular attendance of staff at work and enables managers to manage attendance fairly, with the focus on rehabilitation and return to work wherever possible.

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. The Trust Governance Strategy provides a structured and systematic approach to the identification, prioritisation and management of all risks and ensures that it is integrated into the Trust's philosophy, practices, business planning and operational policies.

The Trust seeks assurances by obtaining documented evidence of compliance, and demonstrating through active and reactive monitoring systems, that it satisfies standards set by both internal and external audit bodies and regulators.

Focused Health and Safety training has been delivered to managers, supervisors and staff in high risk areas which has been very well received by all.

By implementing good risk management strategies, current knowledge and best practice, we ensure that we provide a safe healthcare environment for staff, patients and visitors to our premises in accordance with the Health and Social Care Act 2008 and the Health and Safety at Work Act.

Financial standing and outlook

2011/12 has been a very challenging financial year for the Trust. We have addressed the financial challenge through concerted management action driven through the Trust's clinical divisions and are pleased to be able to report strong financial performance for the year. 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 exceeded, reporting a year-end financial risk rating of 4. 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 2011/12.

In 2011/12 the Trust received total operating income of £337.5 million (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 2011/12 showed a 7.2% increase on income received in the previous year (excluding the technical adjustments described above).

Total operating expenditure (excluding impairment charges) in 2011/12 was £322.7m. Of the total amount spent, £213.3m was spent on pay costs and £109.4m on non-pay costs. The Trust achieved efficiency gains of £11.5m; 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 £13.9m on items such as Public Dividend Capital dividends and interest received on cash balances), the surplus before impairment charges/ reversals for 2011/12 was £1.0m; the plan agreed with Monitor at the start of the financial year showed an anticipated surplus before impairment charges of £0.5m.

Criteria	Metric	Planned score	Actual score	Planned rating	Actual rating
Underlying performance	Earnings before Interest, Tax, Depreciation and Amortisation as a % of income	7.2%	7.2%	3	3
Achievement of plan	Earnings before Interest, Tax, Depreciation and Amortisation as a % of plan	100.0%	102.1%	5	5
Financial efficiency	Return on capital employed	6.9%	7.2%	5	5
Liquidity	Liquidity days	21.0	25.3	3	4
Overall Financial Risk Rating				**3**	**4**

The increased surplus position was primarily due to additional income generated through the delivery of clinical activity to meet patient access targets.

The reversal of impairment charges included in operating income in 2011/12 is £3.7m. 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 £1.0m.

Private patient income accounted for 0.12% 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 2011/12 was £9.2m. Major schemes undertaken in 2011/12 included:

- New Magnetic Resonance Imaging scanner at Calderdale Royal Hospital - £0.5m.
- Refurbishment work on wards at Huddersfield Royal Infirmary - £0.5m.
- Information technology investment of - £1m.
- Replacement of the boiler house at Huddersfield Royal Infirmary to a more energy-efficient plant - £2.4m – completion of scheme commenced in 2010/11.
- Operational and infrastructure schemes - £1.2m.

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.

The work undertaken outside the code was in relation to a review of the arrangements in place within the Trust to produce reference cost data which is submitted to the Department of Health.

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.

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.

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.

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.

Following thorough consultations we will be looking at a number of priorities in the coming year. These include improving care for patients with dementia, reducing hospital readmissions and reducing infections, among others.

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.

Owen Williams
Chief Executive

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

Our vision and values

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

We have a new set of behaviour standards – called The CHFT Way – drawn up after consultation with staff. This was in response to what staff felt was needed and their views were sought in a series of focus groups led by Chief Executive Diane Whittingham and Director of Organisational Development Jan Freer.

The CHFT Way will be incorporated into induction and recruitment, appraisals and training, providing us with a solid foundation that we can all understand, working together to become even more successful in the future.

The seven key standards are:

- Be respectful

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

- Be responsible

We expect people to solve problems at their own level

- Be accountable

Everything is delivered by and through divisions. We are clinically-led and management supported

- Be courageous

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

- Be inspirational

We recognise and reward our staff for their outstanding contributions

- Be positive

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

- Be a team player

We see ourselves as part of the local community and work collaboratively with others to deliver the best outcomes for the people we serve.

Quality Improvement in the Trust

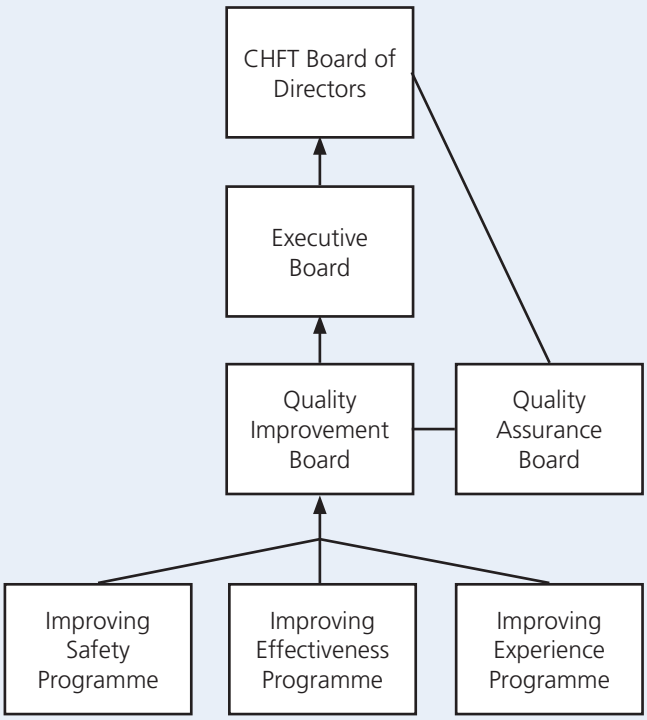
Continuing to improve the quality of care that we provide to our patients is the responsibility of every part of our organisation. Our staff are fully dedicated to our Quality Improvement Strategy aimed at boosting further the quality of care we deliver to our patients.

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

The Safety, Effectiveness and Patient Experience Programmes have an underpinning project structure taking the form of Improvement Collaboratives. Each strand of the programme has an executive sponsor, a programme director and a clinical champion.

We believe that quality improvement is enabled by building capacity and capability in improvement methodology, engaging staff around a clear goal, effective communications, involving patients and members, benchmarking, aligning corporate support systems and robust performance management and individual personal development reviews.

The role of the Quality Assurance Board is to monitor, review and report on the quality of services provided by the Trust to the Board of Directors.



Priorities for improvement and statements of assurance from the Board

How we performed against the seven priorities we set for 2011/12

We are constantly scrutinising the quality of the services we provide to our patients and looking for opportunities to make improvements.

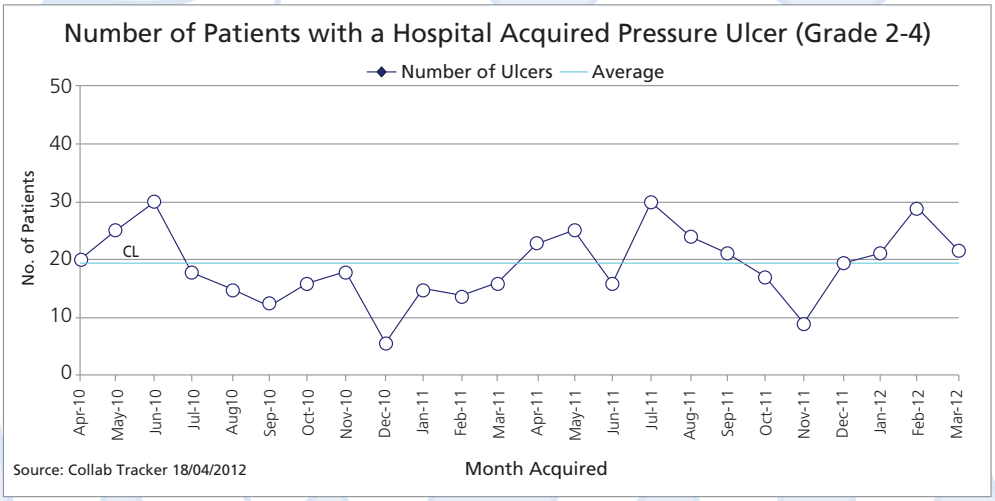
Under the banner 'Safe, Effective and Personal' we aim to build on our strengths as a successful healthcare provider by focusing on key areas so our patients recognise us as a top performing trust and continue to choose us for their care.

Last year we identified seven quality improvement priorities for 2011/12. This section of the Quality Account shows how we have performed against each of these priorities.

Priority one:
Reducing the numbers of pressure ulcers

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

We said we would reduce the incidence of hospital acquired pressure ulcers in 2011/12 by including a further six ward areas into the pressure ulcer improvement collaborative.



The graph shows the number of patients with a pressure ulcer acquired in Trust hospitals on a month by month basis from April 2010. Pressure ulcers are graded 1-4 with grade 4 being the most serious. The total number of patients with hospital acquired pressure ulcers in 2011/12 was 257 which is 25.4% higher than 2010/11. The focused work we have undertaken has seen an increased reporting in all grades of pressure ulcers. We view this transparency positively however we are disappointed to see an increase.

We have continued our work with the safer patients network to implement the SKIN (Surface, Keep Moving, Incontinence and Nutrition) care bundle and have introduced this to all adult inpatient wards. we will continue to ensure reliable practice in the use of the SKIN care bundle.

Intentional care rounds are now widely used within our wards and the SKIN care bundle is included for patients who are at risk of developing pressure ulcers.

Monthly exemplar ward audits monitor compliance with pressure ulcer risk assessment.

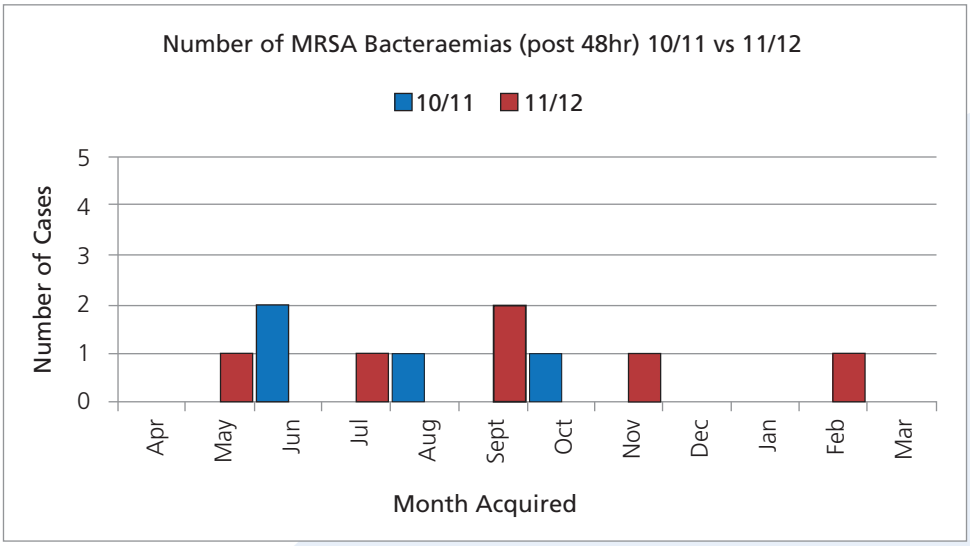
The Trust has continued to work in partnership across the health economy and plans to support partners to introduce the SKIN bundle in other settings outside of hospital.

The work to reduce the incidence of hospital acquired pressure ulcers has been carried forward as a priority for 2012/13. We will be participating in the use of the Safety Thermometer and the transparency work that supports this.

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

Healthcare associated infections are infections that develop as a direct result of medical or surgical treatment or contact in a healthcare setting. MRSA is a type of bacterial infection that is resistant to a number of antibiotics which means that it can be more difficult to treat than other infections.

We believe that by improving the reliability of practice we can reduce the incidence of MRSA bacteraemias further.



The chart shows that the Trust has had 6 MRSA bacteraemias against a target of 5 and has, therefore, not shown any improvement this year.

Whilst this is disappointing we continue with our improvement work around the quality of hand hygiene, insertion and care of invasive devices and the provision of a safe and clean clinical environment.

In addition, this year we have developed and tested improved nursing documentation on the insertion and care of invasive devices and introduced a new bespoke cannulation pack.

Improvements in investigating MRSA bacteraemias allow us to identify the root causes and change practice as a result. For example, the Trust is introducing competency assessment for staff taking blood cultures as a result of a root cause analysis.

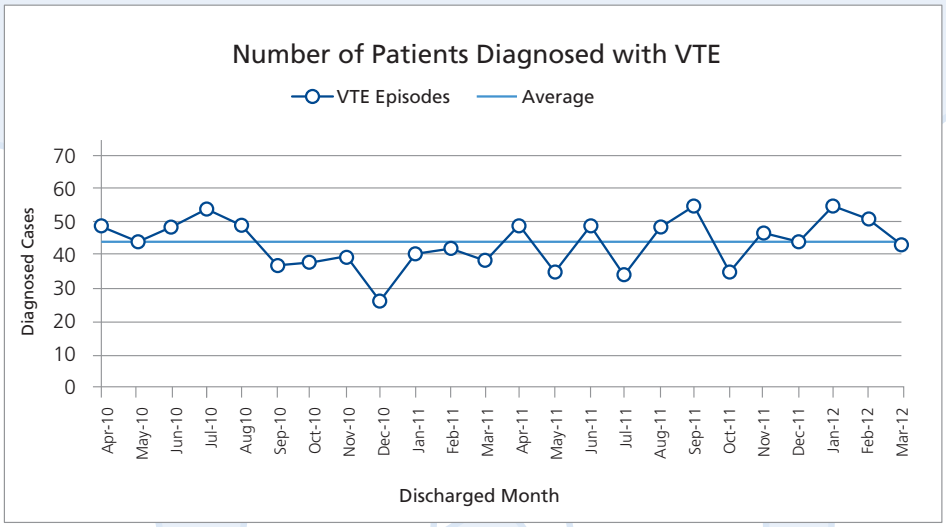
Reducing MRSA bacteraemias has been carried forward as a priority for 2012/13. By continuing to improve the reliability of our processes we aim to have an impact on the number of MRSA bacteraemias.

"We believe that by improving the reliability of practice we can reduce the incidence of MRSA bacteraemias further."

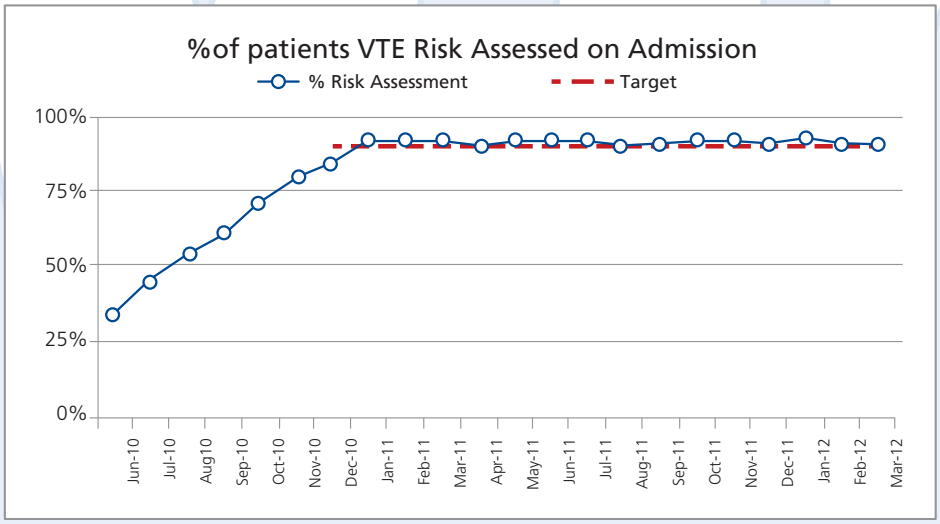
Priority three:
Reducing the number(s) of Venous Thromboembolism (VTE) episodes

Venous thromboembolism is the process by which blood clots occur and travel through veins; it is the collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). The harm caused can be reduced by carrying out timely risk assessments, identifying those most at risk and carrying out preventative measures. It is known that a proportion of VTEs that develop could be avoided by identification of at risk patients and ensuring that these patients get the correct prophylactic treatment. Therefore, by improving the reliability of our processes we know we can reduce harm.

We said we would reduce the harm caused by VTE. Our target has been for 90% of patients to be risk assessed for VTE in 2011/12.

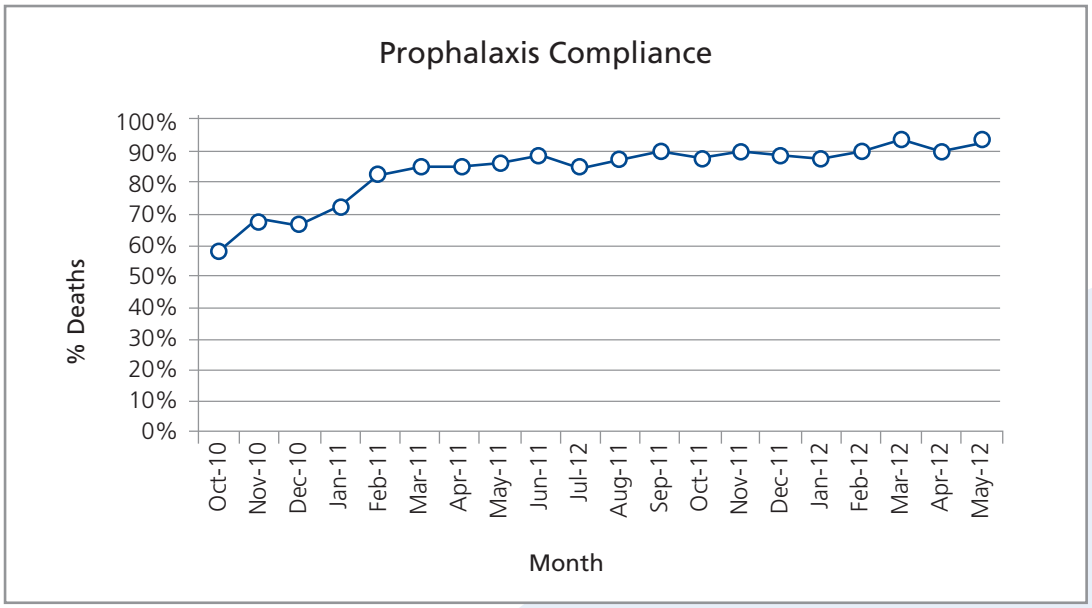


The graph above shows that on average 44 patients are diagnosed with VTE in hospital each month. This makes VTE a significant issue for patient safety. Our aim is to reduce the number of deaths with a primary cause of PE/DVT through risk assessment and appropriate treatment.

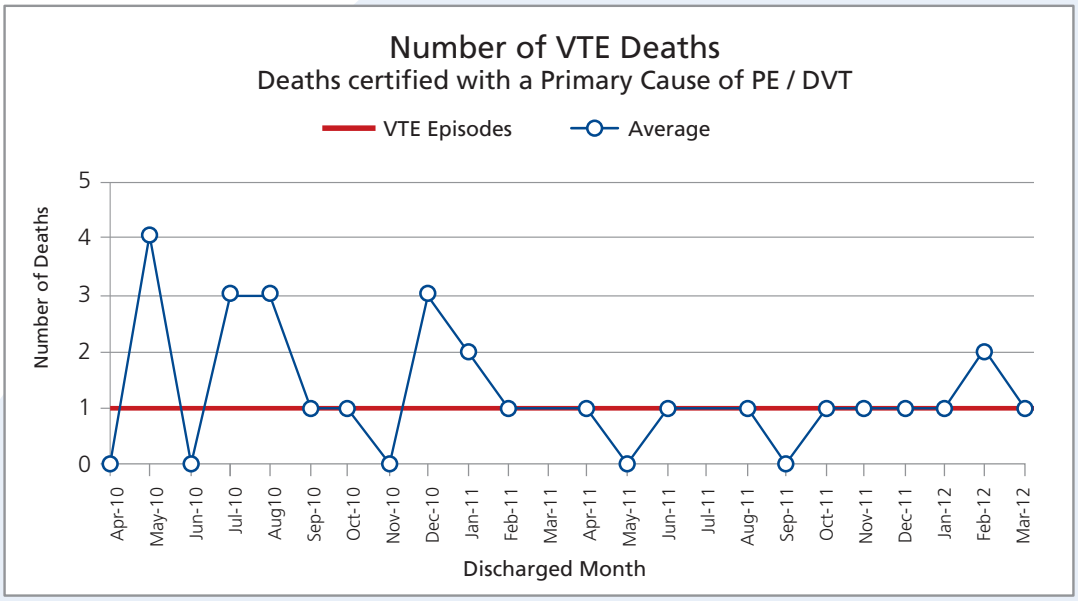


The graph above shows that we have consistently met our target for risk assessment since January 2011. The graph overleaf shows improvement in the percentage of patients who are receiving prophylactic treatment because they have been identified as being at risk of VTE.

Priority three: *(Continued)*
Reducing the number(s) of Venous Thromboembolism (VTE) episodes



In the next chart you can see we have had a sustained reduction in the number of deaths from VTE and this shows that our actions are improving the outcomes for patients.



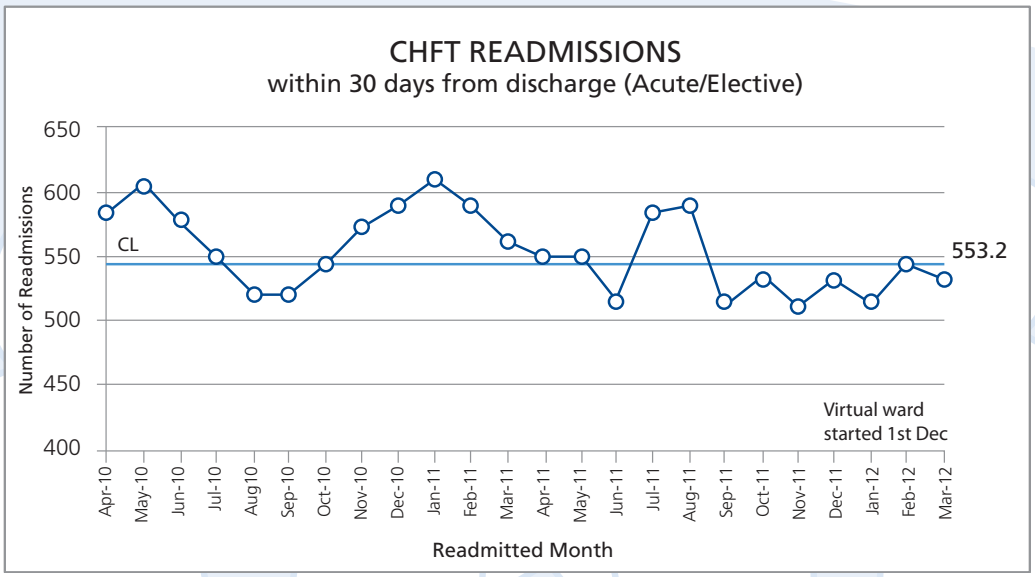
There are two specialist senior nurses who lead on the VTE work; they are responsible for ensuring that risk assessment is carried out and that the correct prophylaxis is given reliably. Work continues to make the process more reliable with adapted prescription charts and other interventions being tested and introduced on the wards. We can expect to see a corresponding reduction in VTE episodes as this work is spread across the Trust.

VTE is not being carried forward as a priority but our improvement work will continue.

Priority four:
Reducing hospital readmissions

In the financial year 2010/11 readmissions to hospital within 30 days cost the Calderdale and Kirklees healthcare economy over £11m.

Our aim for the year has been to do a rigorous analysis to better understand the types of patients who are at risk of readmission and to implement a number of projects and initiatives to reduce the cost by 25%.



The graph above shows clearly that the focus on readmissions in this financial year is starting to deliver results. We have achieved a reduction in the number of patients who have been readmitted within 30 days of discharge from hospital. The rate of readmission in 2011/12 was 8.0% compared with 8.6% in 2010/11.

There are a number of projects working in specialist areas designed to reduce readmissions including the development of care pathways that move care from the hospital setting to the community, and additional services to support patients with alcohol problems.

In addition to these projects, we launched an innovative new virtual ward scheme in December, working in partnership with NHS Calderdale, NHS Kirklees, Locala and South West Yorkshire Partnership NHS Foundation Trust as a pilot. The virtual ward scheme has been adapted from a model used in Toronto. The aim of the scheme is to reduce readmissions by identifying patients who are at high risk of readmission and managing them more effectively in the community.

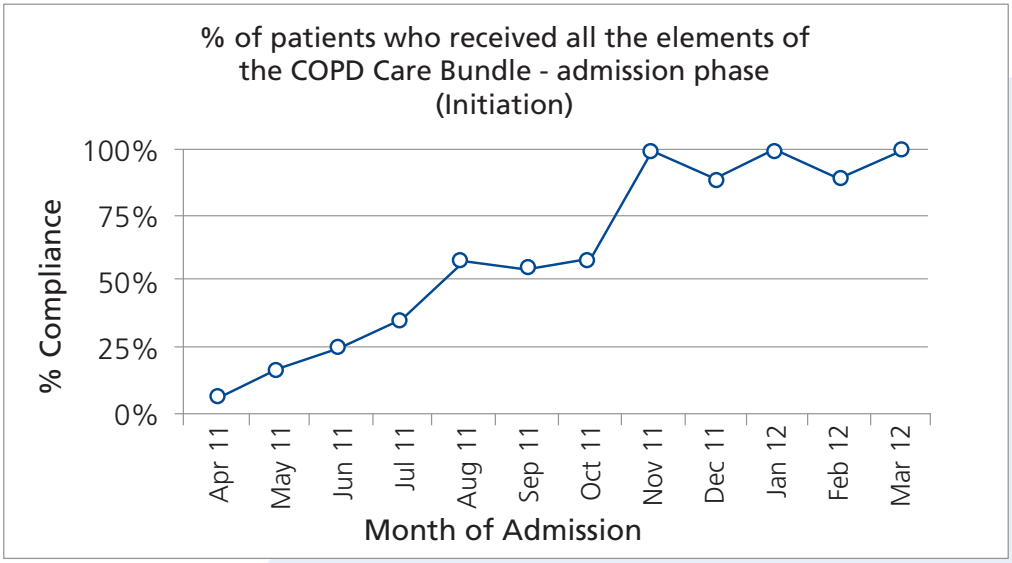
Perhaps more important than the improvements in the figures is the impact on our patients and the positive feedback we have received from the patients and their carers who have been supported by the virtual ward team. We are excited to see the impact that we can make as we extend the readmissions virtual ward to other hospital wards.

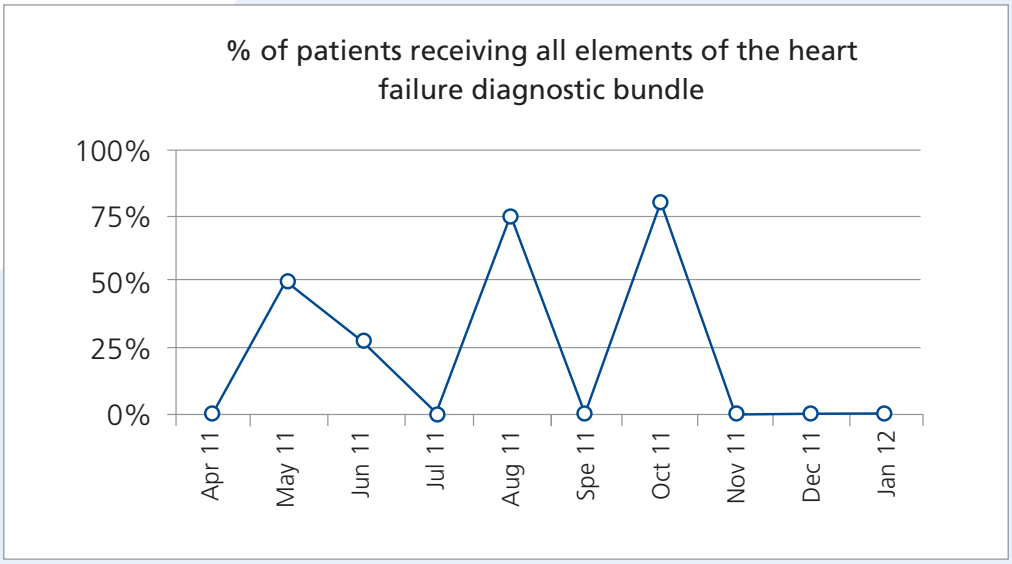
The work to reduce the number of hospital readmissions has been carried forward as a priority for 2012/13.

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

Care bundles are a small number of evidence based actions that all need to be reliably implemented to deliver safe care and achieve the best outcomes for the patient.

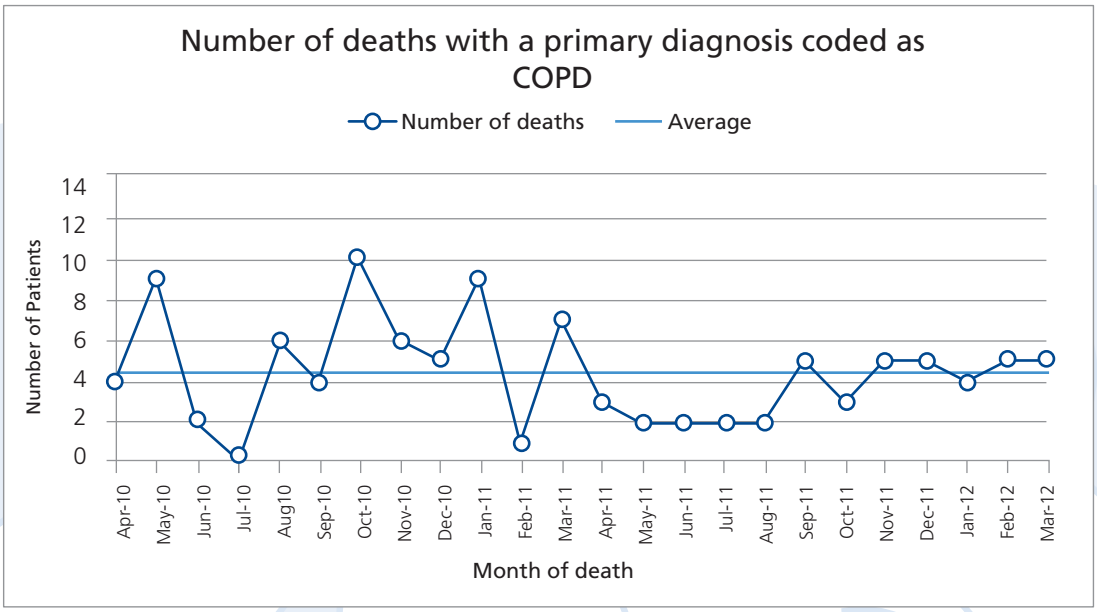
We set out to develop, test and implement care bundles for COPD and heart failure with the aim of improving reliability leading to a reduction in deaths from these conditions. We measured compliance against the care bundles as a whole and for each element. Our target has been to ensure that all relevant patients are commenced on the care bundle and all elements are reliably applied. We have been working to increase compliance on a month by month basis.

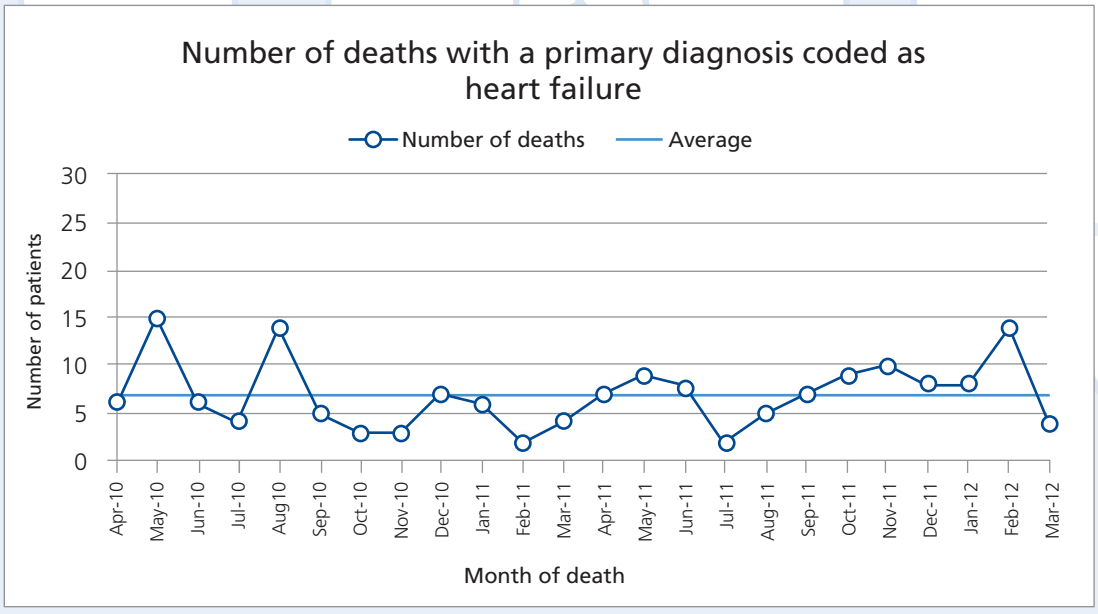




The team initially focused their work around COPD, investigating and understanding how to make the process for initiation and completion of the actions reliable. Work on heart failure is therefore at an earlier stage as you can see from the chart above. Data is not available for February and March 2012. Consistent compliance has not yet been achieved but the lessons learned working on COPD can be applied and therefore the care bundle for heart failure can be introduced more quickly.

Priority five: *(continued)*
Developing care bundles





The charts above show the impact on deaths from the two conditions. From the chart we can see what appears to be the start of a reduction in deaths from COPD. As the work on heart failure is at an earlier stage we have yet to see any impact on the death rate.

This is not being carried forward as a priority but the work will continue towards our target of fully implementing the care bundles for COPD and heart failure throughout the organisation.

Priority six:
Improving doctors' communication with patients

Our National Inpatient Survey results indicated there was some room for improvement in how our doctors communicate with their patients. Publications have stated that whilst 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.

The initial priority this year has been to develop a framework through which improvement work can be driven. This has included:

- The appointment of three consultant leads to represent the three clinical divisions.
- Recruiting champions (tutors) for all clinical specialties.
- Awareness raising with all grades of doctors by presenting specialty specific data via clinical governance half days.
- Interventions are now being tested in specific areas that aim to improve communication, these include:
  - Improving consent training
  - Introducing processes/techniques in outpatient clinics and ward rounds

We have achieved our target to increase the number of consultants attending communication training; this has been delivered to 17 consultants through the Consultant Leadership Development Programme.

In addition, communication skills courses have been delivered to a group of 35 staff grade and associate specialist doctors. The clinical governance half day presentations covered 10 specialty groups and have highlighted concerns regarding doctors' communication and generated ideas for improvement.

A shared learning event is scheduled to help consolidate the learning to date.

The table below demonstrates improvement in some questions relating to doctor communication across all divisions. For each question in the survey, the individual responses were converted into scores on a scale of 0 to 100. A score of 100 represents the best possible response. Therefore, the higher the score for each question, the better the Trust is performing.

The work to improve communications between patients and those caring for them has been carried forward as a priority for 2012/13.

Directorate Scores	Surgery			Medicine & Elderly			CWS	TRUST
Average scores over 2011/12	General Surgery	Orthopaedics	Head & Neck	OPACCS	Medicine	Oncology/ Haematology	Womens	
Sample size:	856	285	86	670	819	98	86	2900
When you had important questions to ask a doctor, did you get answers that you could understand?	77	77	82	73	74	84	84	76
Beforehand, did a member of staff explain what would be done during the operation procedure?	80	82	83	77	82	87	85	81
After the operation procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	77	76	76	70	72	79	81	75
COMPOSITE INDICATOR	78	78	80	73	76	83	83	77

Directorate Scores	Surgery			Medicine & Elderly			CWS	TRUST
Average scores over 2010/11	General Surgery	Orthopaedics	Head & Neck	OPACCS	Medicine	Oncology/ Haematology	Womens	
Sample size:	770	293	96	571	731	75	65	2606
When you had important questions to ask a doctor, did you get answers that you could understand?	74	74	78	70	73	78	77	73
Beforehand, did a member of staff explain what would be done during the operation procedure?	82	79	79	79	81	80	86	81
After the operation procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	71	72	63	76	71	69	77	72
COMPOSITE INDICATOR	76	75	73	75	75	76	80	75

Priority seven:
Improving patient information on discharge

It is important that patients feel confident when going home to ensure that their recovery is as comfortable as possible. Patients must have the correct point of contact should they be concerned about their condition in any way. Giving patients the proper information when they are discharged will help to prevent their readmission.

We said we would measure performance using Real Time Patient Monitoring. Our aim has been to identify the remedial actions for specific wards and to introduce a generic discharge sheet.

Directorate Scores	Surgery			Medicine & Elderly			CWS	TRUST
Average scores over 2011/12	General Surgery	Orthopaedics	Head & Neck	OPACCS	Medicine	Oncology/ Haematology	Womens	
Sample size:	856	285	86	670	819	98	86	2900
Do you feel you are involved in decisions about your discharge from hospital?	79	76	76	78	78	84	83	78
Has a member of staff explained the purpose of the medicines you are to take at home in a way you could understand?	82	83	83	74	79	84	82	80
Has a member of staff told you about medication side effects to watch out for when you are at home? (National CQUIN)	70	63	56	56	58	80	60	63
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	65	64	64	75	70	66	60	68
Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital? (National CQUIN)	77	68	75	69	69	85	78	71
COMPOSITE INDICATOR	**74**	**71**	**71**	**70**	**71**	**80**	**73**	**72**

Directorate Scores	Surgery			Medicine & Elderly			CWS	TRUST
Average scores over 2010/11	General Surgery	Orthopaedics	Head & Neck	OPACCS	Medicine	Oncology/ Haematology	Womens	
Sample size:	770	293	96	571	731	75	65	2606
Do you feel you are involved in decisions about your discharge from hospital?	66	63	63	62	66	72	87	66
Has a member of staff explained the purpose of the medicines you are to take at home in a way you could understand?	72	75	86	62	71	79	93	72
Has a member of staff told you about medication side effects to watch out for when you are at home? (National CQUIN)	48	49	44	38	34	74	81	44
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	55	52	66	64	58	71	68	59
Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital? (National CQUIN)	55	51	52	48	55	75	79	54
COMPOSITE INDICATOR	**59**	**58**	**62**	**55**	**57**	**74**	**82**	**59**

Over the last year a generic discharge sheet has been introduced to improve the level of information that patients are discharged with. Data from the real time monitoring demonstrates that the scores have significantly increased.

Some wards have incorporated this document into other discharge booklets.

One ward has held a focus group which gave patients the opportunity to discuss their experience of discharge and their views on how this could be improved. An information booklet is being developed in response to this.

The work to improve patient experience by providing effective information on discharge has been carried forward as a priority for 2012/13.

Looking ahead to 2012/13

This year we put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our priorities for 2011/12.
- Looking at national priorities and things we have agreed with our commissioners (primary care trusts) as part of Commissioning for Quality and Innovation.
- Considering the priorities in the NHS Operating Framework and NHS Outcomes Framework - both documents shape our approach.

We then asked our patients, staff, members, the general public, the local involvement networks (LINks) in Calderdale and Kirklees, our local authority overview and scrutiny panels, PCT commissioners and clinical commissioning executives what they thought our priorities should be for 2012/13.

This work has helped us to identify the following quality improvement priorities for 2012/13 because they are important to our stakeholders.

The two areas that are no longer highlighted in this report as priorities are 'reducing the number of VTE episodes' and 'developing care bundles for COPD and heart failure'. This does not mean that the work is complete – it will continue alongside many other areas identified in our Quality Improvement Strategy.

Our quality improvement priorities for 2012/13

Safety	Effectiveness	Experience
Reducing the number of pressure ulcers	Reducing hospital readmissions	Improving doctors' communication
Reducing the number of healthcare associated infections – MRSA bacteraemias	Improving the care of patients with dementia	Improving patient information on discharge

Safety

Reducing the number 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 hospital acquired pressure ulcers. Work is ongoing to implement the evidence-based SKIN care bundle across all wards. The number of pressure ulcers remains an important measure of quality.

Improvement work

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

Target

We aim to introduce intentional rounding to all adult medical and surgical wards and, in doing so, reduce the number of hospital acquired pressure ulcers in 2012/13.

Reporting

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

Safety *(continued)*

Reducing the number of healthcare associated infections – MRSA bacteraemias

Why we chose this

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

Improvement Work

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

Target

Our objective is to reduce the number of post 48 hour MRSA bacteraemias to 4 or less in 2012/13.

Reporting

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

Each of our projects have their own measures of reliability around the changes we are making e.g. effective use of the care bundles. The Infection Control Performance Board closely monitors our performance and reports on this to the Executive Board.

Effectiveness

Reducing hospital readmissions

Why we chose this

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

Improvement work

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

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

Target

We aim to reduce the number of avoidable readmissions by a third year on year over the next three years.

Reporting

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

Effectiveness *(continued)*

Improving the care of patients with dementia

Why we chose this

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

Improvement work

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

Target

We aim to achieve compliance with all elements of the dementia CQUIN* in 2012/13. The dementia CQUIN* requires that patients are effectively assessed for dementia and correctly referred for further treatment. In 2012/13 the Trust must achieve at least 90% compliance with the CQUIN* in three consecutive months.

Reporting

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

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

**CQUIN*

The Commissioning for Quality and Innovation (CQUIN) payment framework was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Experience

Improving doctors' communication

Why we chose this

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

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

Improvement work

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

Target

We aim to test, refine and spread current and further interventions, measuring their impact using the doctor specific questionnaires. We hope to increase the Real Time Patient Monitoring scores over the coming year.

Reporting

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

Our aim is to continue to increase the number of doctors who attend communication training and test further interventions that improve doctors' communication and when appropriate spread them to other wards/departments. 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 that all patients have the correct information about their ongoing treatment and care when they leave hospital to ensure a smooth recovery, no unnecessary readmission to hospital and, very importantly, that they maintain confidence in the care they receive.

Improvement work

- Over the last year a generic discharge sheet was introduced to improve the level of information that patients are discharged with. Data from the real time monitoring demonstrates that scores have significantly increased.
- The following questions from the National Inpatient Survey will be used to measure improvement via the monthly Real Time Monitoring report: Improving information on discharge:

Q1 Were you told about medication side effects to watch out for when you went home?

Q2 Were you told who to contact if you were worried about your condition after you left hospital?

Target

We aim to monitor data at individual ward level to ensure improvements are sustained and take remedial action as required to improve the scores over the coming year.

Reporting

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

Statements of assurance from the board

Review of services

During 2011/12 the Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 41 NHS services.

The Calderdale and Huddersfield NHS Foundation Trust has reviewed all the data available to it on the quality of care in 32 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 30.6% of the total income generated from the provision of NHS services by the Calderdale and Huddersfield NHS Foundation Trust for 2011/12.

Participation in Clinical Audits

During 2011/12, 42 of the national clinical audits and five national confidential enquiries covered NHS services that Calderdale and Huddersfield NHS Foundation Trust provides.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 95% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. Details can be found in Appendix A.

Participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Calderdale and Huddersfield NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1,237.

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

In 2011/12 Calderdale and Huddersfield NHS Foundation Trust hosted a total of 153 clinical research studies of which 120 had a principal investigator employed by the Trust. Studies were conducted across 29 different medical specialties although the main research effort (68%) was concentrated within the four specialties: Oncology (60 studies, 39%); Paediatrics (23, 16%); Stroke (10, 75%) and Ophthalmology (9, 6%).

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

There were 79 clinical staff participating in research approved by a research ethics committee at Calderdale and Huddersfield NHS Foundation Trust during 2011/12

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

Through our engagement with clinical research we have been able to pilot delivering therapies not usually available on site e.g. advanced imaging techniques – Positron Emission Tomography – with a view to possibly adding these techniques to our range of available treatments. This also demonstrates Calderdale and Huddersfield NHS Foundation Trust's commitment to testing and offering the latest medical treatments and techniques.

Goals agreed with commissioners

Calderdale and Huddersfield NHS Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The figure for CQUIN received for 2011/12 was £1,898,165.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available online at: http://www.institute.nhs.uk/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 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 2011/12.

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

Data Quality

Calderdale and Huddersfield NHS Foundation Trust will be taking the following actions to improve data quality:

- Continue to monitor compliance with the NHS Number Mandate and establish a process to ensure all service and system developments fully encompass national NHS Number standards.
- Continue to quality assure developments in the Trust's Patient Administration System and other clinical information systems; to ensure that data quality and standards are addressed within the development and delivery of the Trust's Digital Strategy.
- Establish processes to ensure that patient demographic updates are shared between the Patient Administration System and the clinical applications in the separate SystmOne system.
- Establish a framework for data quality audits that allows the assurance for each data item to be clearly demonstrated.
- Continue to build an intranet-based library of data quality protocols and guidance; identify opportunities to develop direct access to this guidance from the Trust's PasWeb application.
- Continue to update documentation evidencing how local systems enforce national data definitions.
- Continue to develop procedures for validating the quality of activity data submissions required by commissioners, including the newly established requirements for community and radiology activity; to provide timely feedback to data collectors; to reduce the number of data quality queries raised by commissioners.
- Improve aspects of A&E data quality as agreed with the main commissioner.
- Establish data quality control and assurance frameworks for each key performance indicator.

These actions incorporate:

- Actions required to achieve a level 3 score on the data quality requirements of the Information Governance Toolkit.
- Issues agreed for improvement with the Trust's main commissioner.

NHS Number and General Medical Practice Code Validity

Calderdale and Huddersfield NHS Foundation Trust submitted records during 2011/12 (April 2011 to December 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:

a) which included the patient's valid NHS number was:

99.8% for admitted patient care;

99.9% for outpatient care; and

98.0% for accident and emergency care.

b) which included the patient's valid General Medical Practice Code was:

100.0% for admitted patient care;

100.0% for outpatient care; and

100.0% for accident and emergency care.

Information Governance

Calderdale and Huddersfield NHS Foundation Trust Information Governance Assessment Report overall score for March 2012 was 78% and was graded unsatisfactory. Despite an overall high percentage score, we have been classified as 'unsatisfactory' because we are at level 1 for two of the 45 standards. We did however achieve the maximum level (Level 3) for 18 of the 45 standards. Our score puts us in the top 30% of NHS organisations in Yorkshire and the Humber and we have identified a number of further activities aimed at improving our performance next year.

Clinical coding error rate

Calderdale and Huddersfield NHS Foundation Trust was subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were 9.6%. The overall finding of the audit commission review was that the Trust's performance is slightly better than the national average.


NHS

Additional Information

Review of quality performance – how we compare with others

In this section you will find more information about the quality of services that we provide by looking at our performance over the last year and how we compare with other trusts, where the data is available to us.

We have chosen nine quality indicators that cover a broad range of services and specialties. Many of the indicators that we have selected are the same as those we chose last year so that you can see that we continue to invest our efforts in these important areas. However, last year we included the national maternity survey that is undertaken every two years. This year we have included patient experience in accident and emergency as another key indicator of patient experience within the organisation. We have also included length of stay in medicine in the place of cancelled operations because this is a key indicator of the effectiveness of the healthcare system and it is an area that has been a focus for the organisation and its partners over the last 12 months.

Safety	Effectiveness	Experience
Hospital Standardised Mortality Rates (HSMR)	Cancer Waiting Times	Real Time Patient Monitoring
Falls in hospital	Stroke	End of life care
Healthcare Associated Infections	Length of stay in medicine	Patient experience in accident and emergency

Several new initiatives have been introduced in 2011/12 which have enhanced the quality of care we deliver.

Case Study 1: £2 million new blood laboratory

Blood tests and the results for patients are now faster after a £2m investment.

In partnership with Siemens a state-of-the-art automated tracking system has been installed in the laboratory which tests up to 3,000 samples every day.

It means the test time for each sample – now carried out by automation - is reduced from an hour to around 40 minutes through continuous travel without the need for the samples to be carried between each process.

Conditions which the blood is tested for in the laboratory include diabetes, anaemia, cholesterol, tumours, leukaemia and drug-level monitoring.

A team of 40 biomedical scientists and support staff and laboratory assistants will work round the clock performing the tests for inpatients and also GP requested tests.

Pathology services manager Sharon Appleby said: "The investment brings the laboratory at Huddersfield Royal Infirmary up to the national gold level standards which means we have, in short, the very best equipment in the country for our patients.

"The laboratory is a tremendous asset for the Trust and an amazing overhaul of the existing equipment and facilities of which we are very proud. Reducing the test times will be of special benefit to A&E staff who need the information quickly."

There has also been £500,000 refurbishments of the laboratory including new work surfaces replacing traditional wooden benches and new windows throughout.

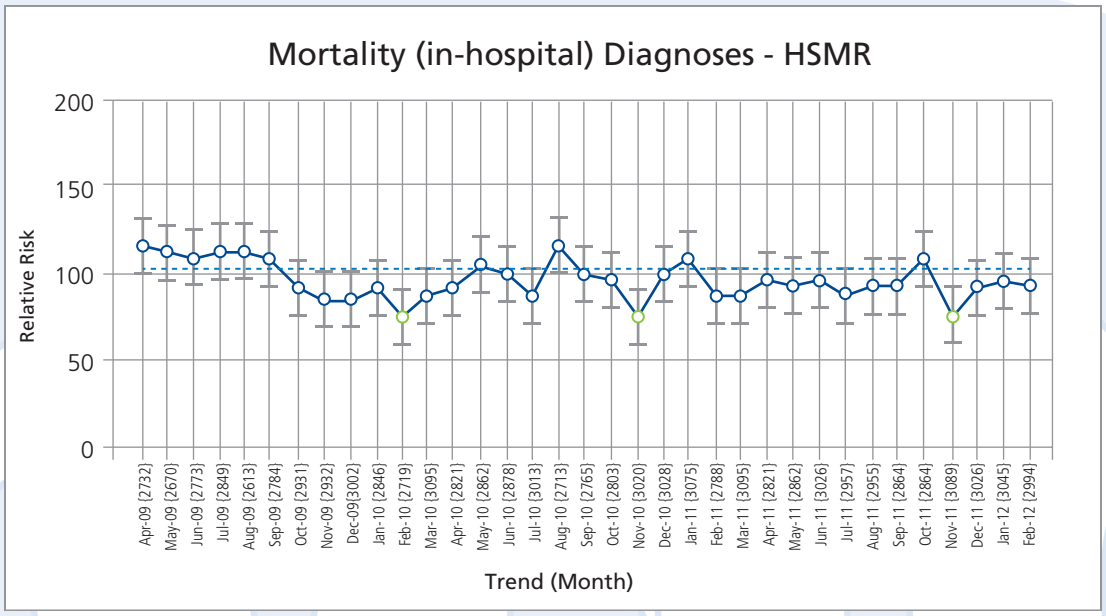
Automated tracking in the laboratory

Safety

Hospital Standardised Mortality Rates (HSMR)

Why we have chosen this

HSMR is a national measure that is used to compare our death rates to those of other trusts. It alerts us when we have more than the expected number of deaths for our population from certain clinical conditions, and from this we are able to look in more depth at causes.



Commentary

The chart above shows our monthly HSMR rate for all the clinical conditions included; we aim to be below the 100 line as this tells us we have a mortality rate below that which is expected for our population. As you can see for the past nine months we have only had one point above the 100 line.

Our performance on HSMR is closely monitored and when we have a higher than expected mortality rate for certain conditions these are discussed and investigated thoroughly; where necessary changes are put in place.

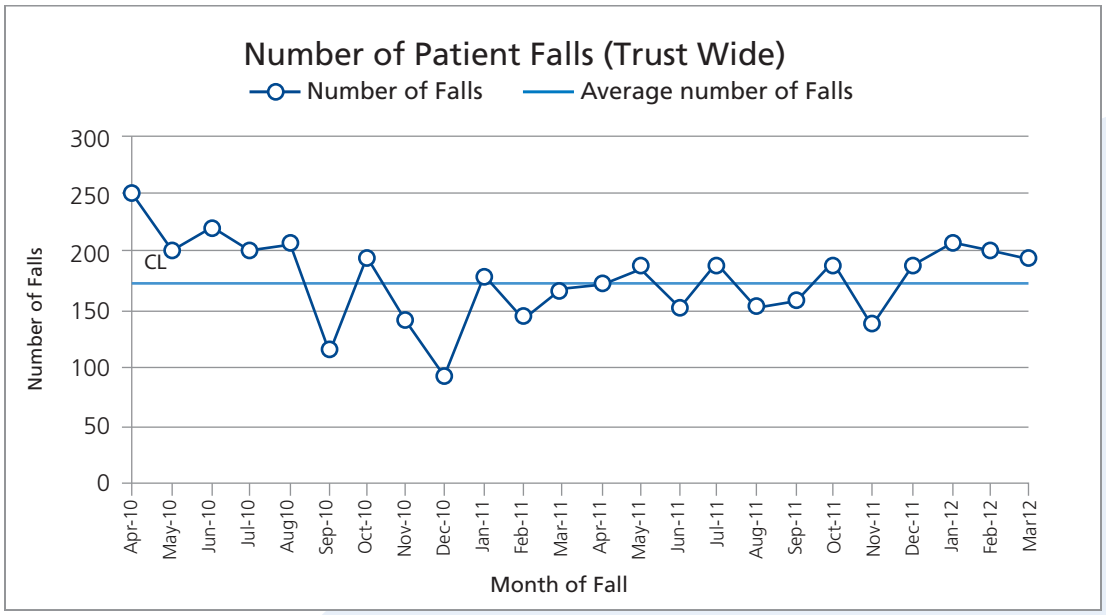
Data for March 2012 is not yet available.

Safety

Falls in hospital

Why we have chosen this

We are 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 related harm is part of our exemplar ward programme.



Commentary

The above graph shows the number of falls each month within the Trust. The light blue line shows the average number of falls each month.

We had a total of 2,111 falls in 2010/11 compared with 2,129 in 2011/12 - this represents a 0.9% increase Trust-wide. We have increased the number of wards that have been testing interventions to reduce the number of inpatient falls that occur on ward areas.

Safety

Healthcare associated infections (HCAIs)

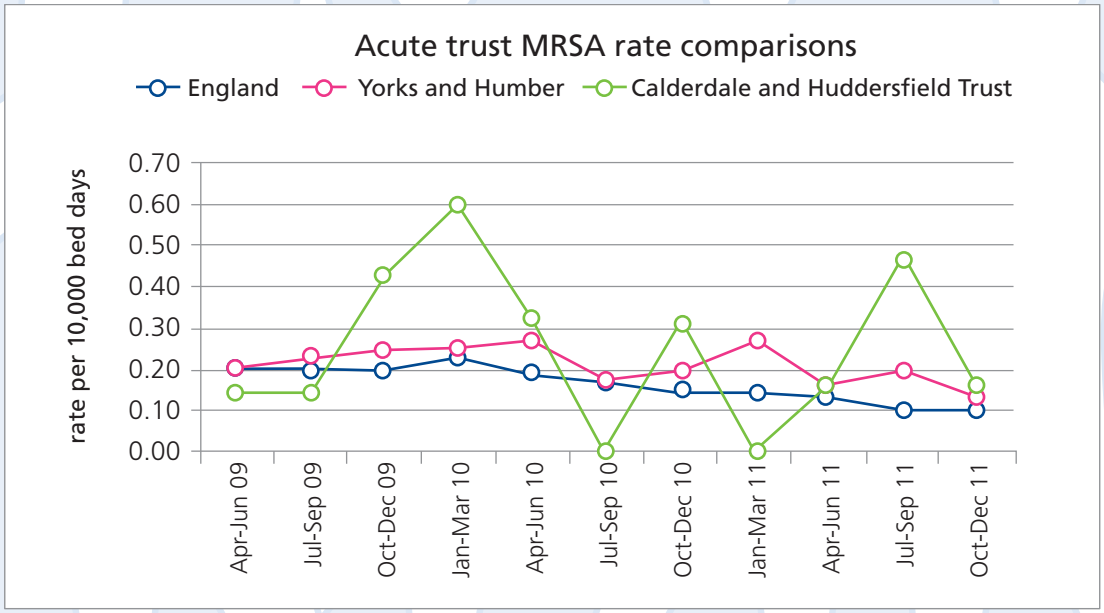
Why we have chosen this

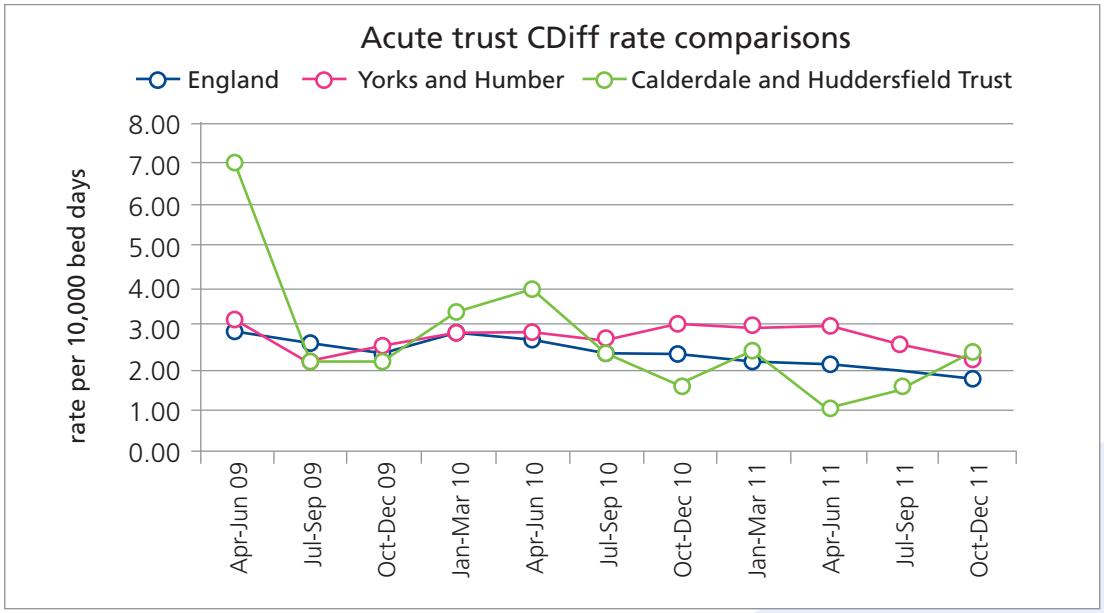
HCAIs are infections that are acquired as a result of healthcare interventions. There are a number of factors that increase the possibility of infection but high standards of infection control practices minimise the risk.

Clostridium difficile is a bacterium that can cause symptoms ranging from diarrhoea to life-threatening inflammation of the colon. Illness from Clostridium difficile most commonly affects older adults in hospitals or long term facilities.

Methicillin-resistant Staphylococcus aureus (MRSA) is a bacterium responsible for several infections that are difficult-to-treat because it is multidrug-resistant.

As a Trust we have performed well in the region for our rates of HCAI although we acknowledge there are further improvements to be made. The changes that have been undertaken were multi faceted and involved different teams of staff working together to increase the reliability of our processes.





Commentary

The previous charts have been provided by the Health Protection Agency that is responsible for monitoring healthcare associated infections with mandatory and voluntary surveillance schemes. The Health Protection Agency was not able to provide data for the final quarter of 2011/12.

Improvement work on healthcare associated infections involved improving both our preventative measures and then early detection, treatment and isolation of patients with the infection.

For preventative work, improvements have been made around the use of antibiotics, ensuring all antibiotics are prescribed correctly and are only used where necessary. Other work has been around the provision of a safe and clean clinical environment, monitoring and making improvements where necessary.

The second stage was around working with staff, helping them to recognise possible infections as early as possible; we have just introduced a new two stage test to improve the accuracy of diagnosis in line with Department of Health guidance. Early recognition allows us to isolate and treat the patients more quickly thus improving patient outcomes and reducing the possibility of spread. The laboratory, infection control and bed management teams have worked closely together to ensure this happens as quickly as possible.

Effectiveness

Cancer waiting times

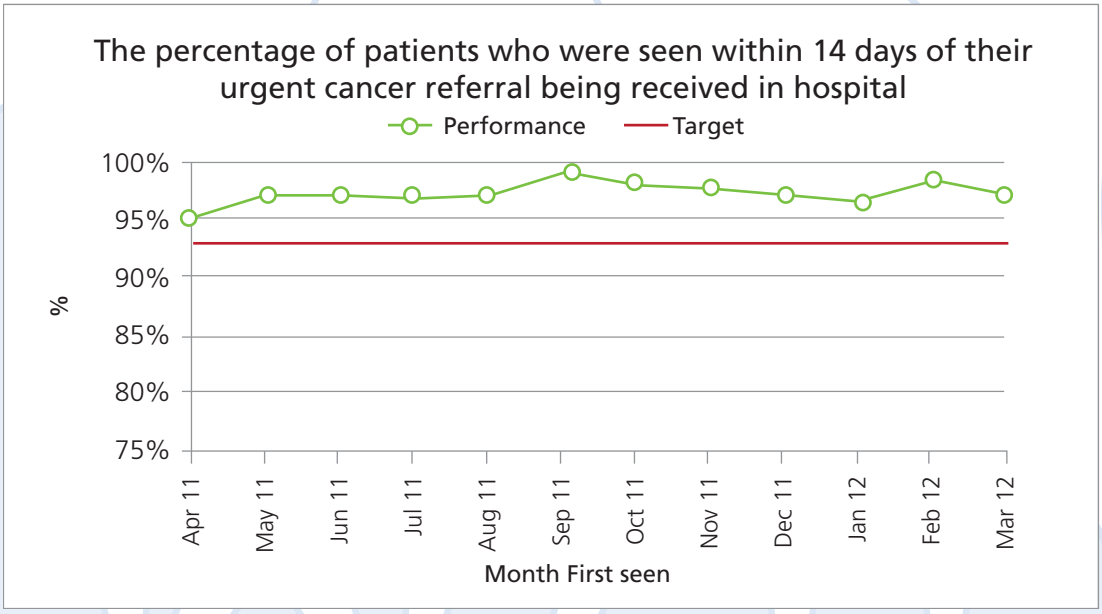
Why we have chosen this

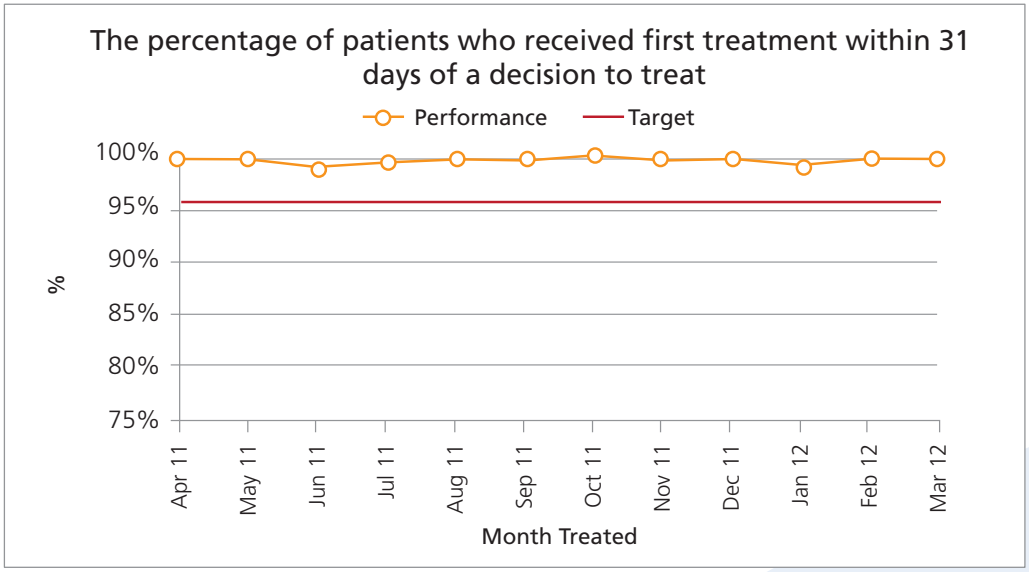
Currently about 1.8 million people are living with and beyond a cancer diagnosis and surveys show that people fear cancer more than anything else. Many require several different tests to diagnose their cancer accurately and then a combination of different treatments such as surgery, radiotherapy and chemotherapy. Rapid access to high quality services and effective coordination between different parts of the NHS can save lives and improve the quality of life for patients.

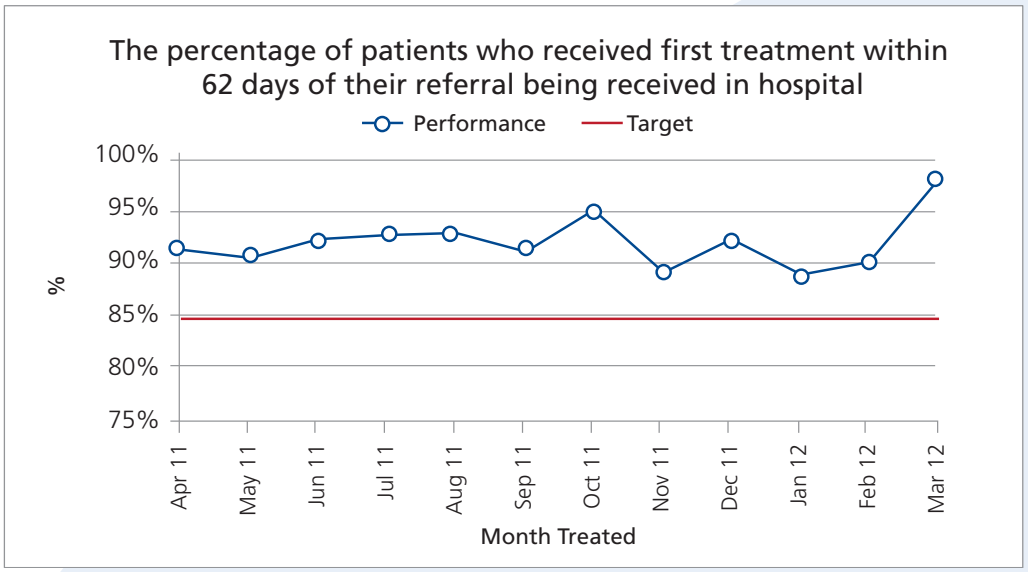
Nationally there is a drive to improve early diagnosis by increasing public awareness of the signs and symptoms of cancer. The Trust has been part of the national bowel cancer screening initiative which has informed the public on the signs and symptoms of bowel cancer.

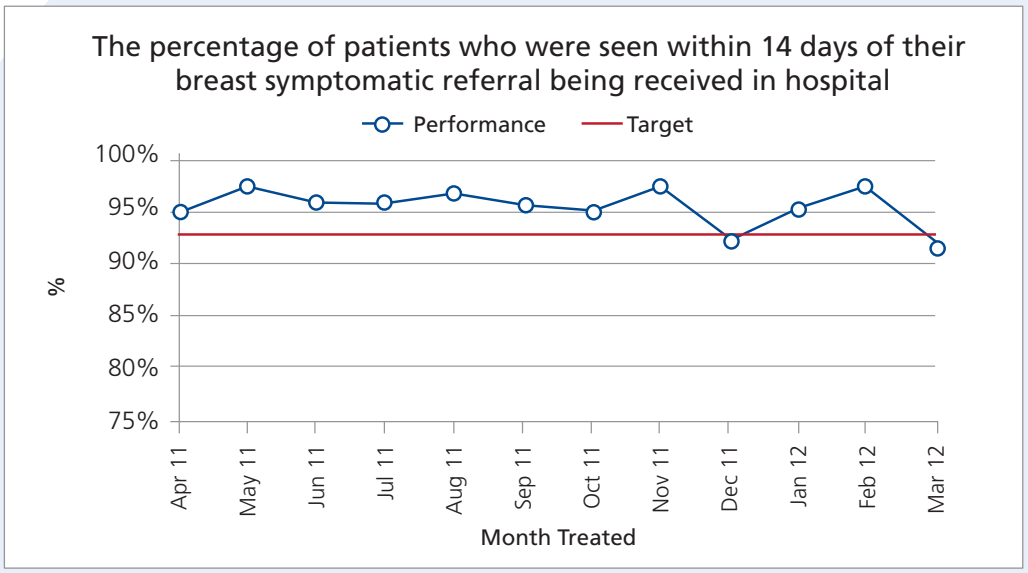
Half of the people diagnosed with cancer today will still be alive in five years time and more than 40% will still be alive in 10 years time. The average 10 year survival rate for cancer has doubled in the last 30 years.

Current drives are to support patients living with and beyond cancer and there are many national cancer survivorship initiatives being launched. The Trust has led on supported self-management for breast cancer patients which has been recognised nationally as being of huge benefit to these patients.




The percentage of patients who received first treatment within 31 days of a decision to treat
Performance
Target
100%
95%
90%
85%
80%
75%
%
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Month Treated


The percentage of patients who received first treatment within 62 days of their referral being received in hospital
Performance
Target
100%
95%
90%
85%
80%
75%
%
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Month Treated


The percentage of patients who were seen within 14 days of their breast symptomatic referral being received in hospital
Performance
Target
100%
95%
90%
85%
80%
75%
%
Apr 11
May 11
Jun 11
Jul 11
Aug 11
Sep 11
Oct 11
Nov 11
Dec 11
Jan 12
Feb 12
Mar 12
Month Treated

Benchmarking

Target	Apr 11- Feb 12 CHFT	Apr 11- Feb 12 YCN	Apr 11- Feb 12 National
14 Day	97.49%	95.3%	95%
31 Day	99.85%	97.6%	98.3%
62 Day	92.02%	83.70%	86.80%
14 Day Breast	95.54%	95.50%	94.20%

KEY:

YCN	Yorkshire Cancer Network
CHFT	Calderdale and Huddersfield NHS Foundation Trust

The benchmarking values will differ slightly to performance data reported against national priorities due to the timing of information being available.

Commentary

The percentage of patients who were seen within 14 days of their urgent cancer referral being received in hospital

The requirement for this target is 93%. Our performance against this target remains strong, above both the Yorkshire Cancer Network (YCN) and national performance.

The percentage of patients who received first treatment within 31 days of a decision to treat

The requirement for this target is 96%. Our performance against this target remains strong, above both the YCN and national performance.

The percentage of patients who received first treatment within 62 days of their referral being received in hospital

The requirement for this target is 85%. Our performance against this target is strong, above both the YCN and national performance and an improvement on the previous year.

The percentage of patients who were seen within 14 days of their breast symptomatic referral being received in hospital

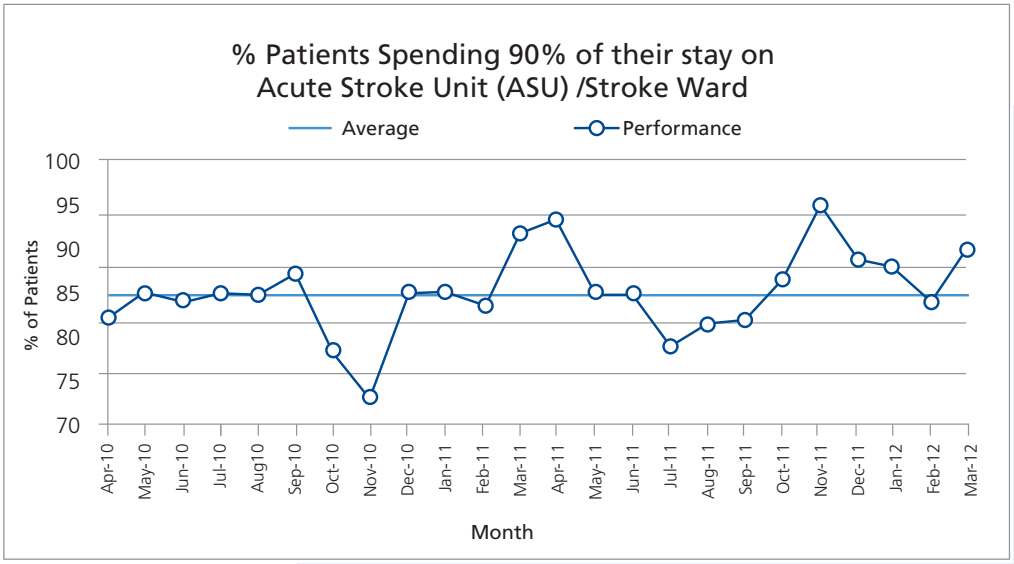
The requirement for this target is 93%. For the year to date, performance is at 95.8% which is higher than the national average and slightly higher than the average across the YCN and lower than our performance last year. Appointments are offered to patients but there are factors that affect choice as some patients and their GPs do not necessarily have a strong suspicion of cancer at this time.

Effectiveness

Stroke

Why we have chosen this

Strokes are caused by a blood clot or bleeding in the brain. It is estimated that 150,000 people in the UK have a stroke every year. One third of those who suffer from a stroke will die within the first 10 days, about a third will make a recovery within one month and a third are likely to be left disabled and requiring rehabilitation. Stroke patients occupy around 20% of all acute hospital beds. It is important that stroke patients are treated on stroke specialist wards because stroke patients who are treated on general wards have a 14% to 25% higher mortality rate than those on stroke units.



Commentary

This year we have invested in stroke services. We now employ six thrombolysis nurses and this has contributed to an overall improvement in performance. A high percentage of patients are admitted to the hospital acute stroke unit and consultants undertake daily ward rounds. Overall, 88.7% of stroke patients spent at least 90% of their hospital stay on our Acute Stroke Unit or specialist ward. This is compared to 86.5% in the previous year.

A Peer Review has commenced across Yorkshire and the Humber. The focus of the review is on operational standards, standards of patient care/information and the acute phase of the patient pathways and follow ups. So far we have received positive feedback on the written documents we have provided.

There is still room for improvement. Thrombolysis only takes place within office hours at present but we are working with the consultants to provide a 24-hour service in the not too distant future. A new consultant stroke specialist will be joining the Trust in June 2012 and TIA clinics (transient ischaemic attack, often referred to as mini stroke), will be provided seven days a week within the next few months.

Thrombolysis is treatment that breaks down (lysis) blood clots by pharmacological means.

TIA is a transient episode of neurologic dysfunction caused by ischemia (loss of blood flow).

"It is estimated that 150,000 people in the UK have a stroke every year"

Effectiveness

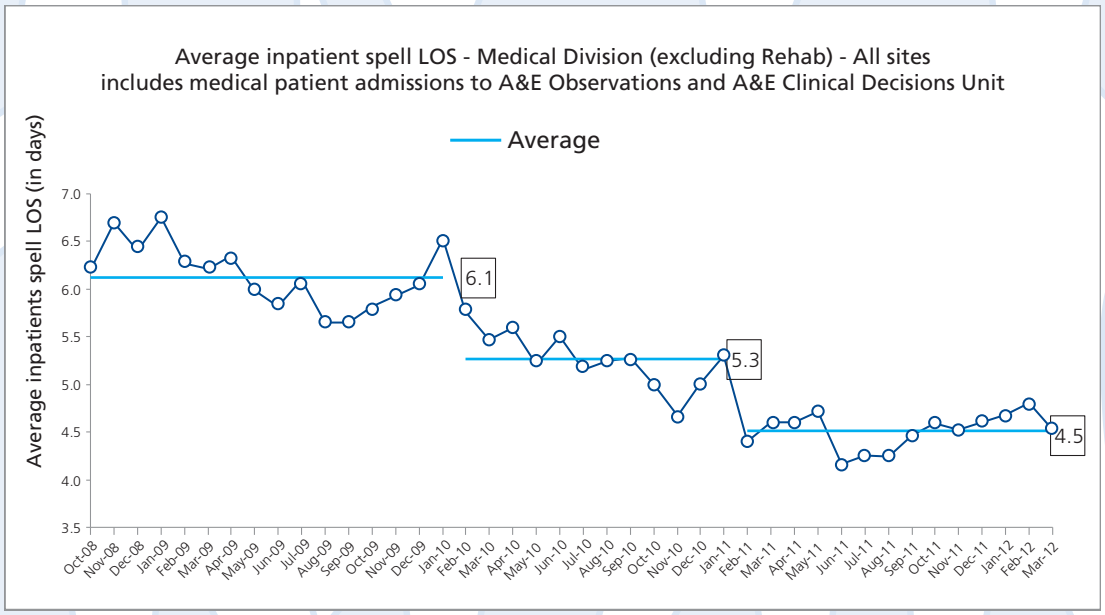
Length of stay in medicine

Why we have chosen this

Length of stay (LoS) is a key indicator which can have a significant and beneficial effect on quality, safety and efficiency. Reducing length of stay (in a controlled and purposeful way) has a positive effect on a range of issues that the Trust faces:

- Reducing avoidable deaths and harm.
- Safety indicators such as falls, pressure ulcers and infections.
- Patient experience (by reducing waiting times either whilst an inpatient or whilst waiting to come into hospital).
- Financial pressures and cost reduction.

Length of stay is the one single area that we can work on which will have multiple beneficial effects for our Trust and can help overcome the challenge we face of increasing the quality of service we provide with significantly reduced costs.



Benchmarking 2011/12

In quarter three of 2011/12 we had the fourth lowest overall average length of stay when compared with 44 large acute Trusts using Dr Foster ratings. Dr Foster provides comparative information on health and social care services in the UK.

Commentary

The Trust approach to reducing length of stay has been through pieces of work to ensure that patients get what they need on time. Whilst in hospital it is a fact that patients spend a lot of time waiting for things to happen (getting tests done, seeing a doctor, getting drugs ready to be taken home etc.).

Through the implementation of Visual Hospital and Plan for Every Patient the amount of time patients spend waiting has dramatically reduced, the cumulative effect being a significant reduction in length of stay particularly for medical patients. The chart above illustrates this reduction over time. This is ongoing work and we expect to see further reductions in the future.

Case Study 2: Calderdale Community Breast Feeding Team

New mums in Calderdale have some of the most supportive teams in the country to care for them.

Calderdale Community Breast Feeding Team – part of the Calderdale and Huddersfield NHS Foundation Trust - has just received its second stage accreditation from Unicef.

The team has held stage 1 since 2010 but has now achieved stage 2.

Infant feeding coordinator Alison Bottomley, said: "Mums want accurate, non-conflicting advice at this time in their lives, when it feels like there is so much new to learn. We want them to feel confident and supported with their babies so they can enjoy this special time."

Mum Laura Clegg, from Brighouse, said: "I have had a lot of advice and support and have had a home visit which really helped. It makes a difference to know there is someone there to support me, particularly with two babies."

To achieve stage 2 of Unicef's best practice standards, staff were interviewed on all aspects of breastfeeding and assessed on a practical level. These aspects included: instructing a mother on the best position for the baby to feed effectively, expressing milk by hand, recommendations for commencement of weaning, advice on night-time feeds and supporting breastfeeding mums when they return to work.

To gain stage 2 they also had to demonstrate good information links with GPs. The GPs in Calderdale have all received a pack of information about breast feeding and the sources of support and practical help mothers can access.

* The Unicef Accreditation scheme takes place in 3 stages. The scheme aims to provide involved professionals with the knowledge and expertise to support mothers to feed for as long as mums wish to continue feeding for.

Mums get breast feeding advice at clinic

Experience

Real time patient monitoring

Why we have chosen this

The Trust introduced a system of Real Time Patient Monitoring (RTPM) 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.

"I came into the assessment ward around 1pm. Everything was done – tests, x-rays, doctor visit – and because I was a straight forward case I was able to be discharged around 6.30pm. I was given antibiotics to sort out my problem with a follow up x-ray in six weeks. I was treated very well by everyone."

Commentary

Each ward receives its individual results on a quarterly basis, along with a 'ward map' (overleaf) which details cumulative data (rolling 12 months); this includes all wards and all questions.

This provides an excellent opportunity for wards to focus on the areas that require improvement, using the data provided to link with wards that are scoring well.

In the last 12 months 2,900 surveys have been carried out across the Trust, between 81 and 123 per ward.

Comparison with the individual scores from last year shows that 19% have improved by more the 10 points and a further 16% have increased by 5 – 9 this year. 13% of scores have reduced by 5 points or more. Many of the improved scores relate to the questions about discharge.

Work is now taking place to establish a robust process for gathering similar information regarding the outpatient services.

Real time patient monitoring *(continued)*

Ward Scores Map - Q4 2011/12
Inpatient RTM

Average Annual Scores
Apr - Mar 2011/12

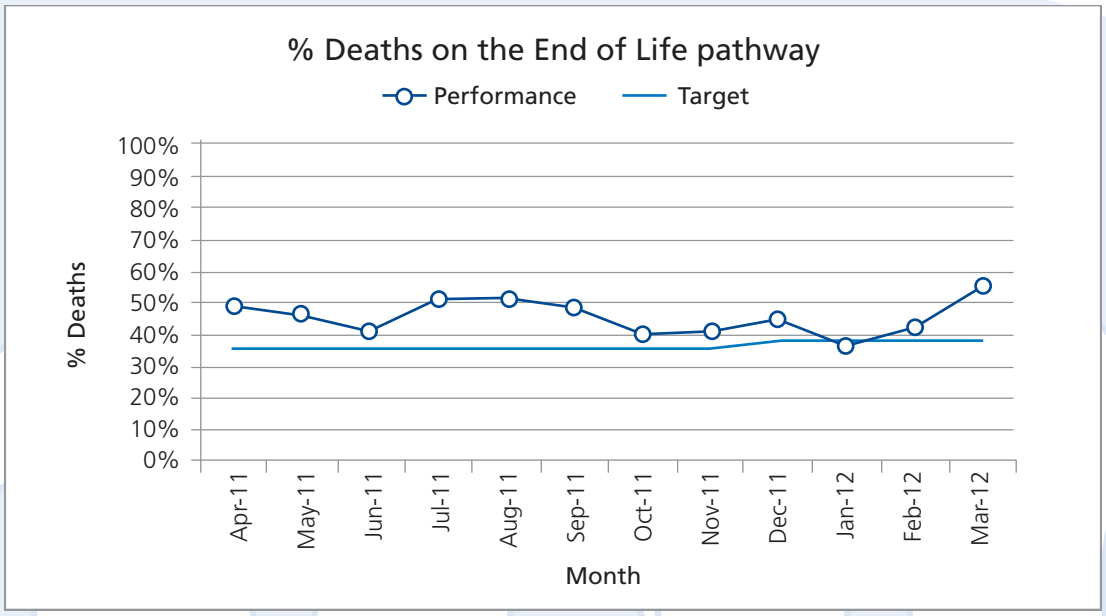
		Surgery												Medicine & Elderly																CWS			
		General Surgery								Orthopaedics			Head & Neck	OPACCS							Medicine									Women		HRI	CRH	TRUST
		A&E CDU (HRI)	A&E CDU (CRH)	Surgical Assessment Unit	10 General Surgery	15 General Surgery	80 General Surgery	3 Vascular	22 Urology	19 Orthopaedic	20 Trauma & Orthopaedics	BAB Orthopaedic	8C ENT/Opht/Maxillo Ofr	4 Complex Care	7 Complex Care	5CD Complex Care	7AD Rehab / Complex Care	6D Acute Stroke Unit	21 Stroke Rehab Unit	7BC Stroke & Neuro Rehabilitation	1 MAU	2CD MAU	2AB Short Stay	6 Short Stay Unit	17 Gastro/Complex Care	5B Respiratory	3 Cardio Respiratory	6BC / CCU Cardiology & Coronary Care	12 Oncology / Haematology	4CD Gynaecology			
	# of Surveys:	94	82	106	108	105	91	91	116	103	85	97	86	89	86	84	105	84	94	84	105	86	88	123	94	81	113	89	98	84	1757	1143	2900
1	From the time that you arrived at the hospital, did you feel you had to wait a long time to get to a bed on a ward?	74	82	71	73	67	81	73	66	62	76	72	76	70	69	81	79	86	80	84	60	71	73	54	81	82	68	80	78	84	69	79	73
2	During this stay in hospital, have you ever shared a sleeping area, for example a room or bay, with patients of the opposite sex?	89	40	89	88	86	90	89	89	93	87	88	90	87	84	91	90	74	91	92	82	90	92	83	91	92	76	-	92	93	86	85	86
3	Are you ever bothered by noise at night by hospital staff?	74	84	75	82	78	84	82	78	74	72	74	91	84	73	75	81	86	83	73	66	82	80	76	83	82	72	85	86	82	78	81	79
4	In your opinion, how clean is the hospital room or ward that you are in?	83	85	88	89	87	89	86	87	87	87	89	88	89	86	87	91	90	89	90	85	88	89	87	89	88	88	90	90	90	87	89	88
5	How would you rate the hospital food?	52	56	46	43	46	50	37	49	60	43	56	66	55	64	62	58	54	49	67	62	62	33	60	51	56	55	36	40	68	52	57	54
6	When you have important questions to ask a doctor, do you get answers that you can understand?	70	82	72	77	83	80	79	75	75	77	82	82	80	70	59	71	81	74	71	68	75	72	69	73	75	77	85	84	84	75	77	76
7	As far as you know, do doctors wash or clean their hands between touching patients?	75	85	84	87	82	83	86	79	82	83	89	85	83	82	80	81	89	85	84	81	85	82	78	84	81	84	87	89	89	83	85	83
8	As far as you know, do nurses wash or clean their hands between touching patients?	78	90	86	90	89	89	91	87	88	87	88	89	89	87	88	92	91	91	90	83	88	89	86	88	86	90	89	89	91	87	89	88
9	Are you involved as much as you want to be in decisions about your care and treatment? (National CQUIN)	62	77	72	79	78	78	73	72	72	74	81	75	70	68	60	69	73	69	63	66	80	66	67	66	74	76	83	85	83	72	74	73
10	How much information about your condition or treatment has been given to you?	67	85	72	77	67	86	76	68	75	74	89	83	74	65	67	76	79	71	73	70	81	71	64	79	76	75	85	89	79	72	79	75
11	Have you found someone on the hospital staff to talk to about your worries and fears? (National CQUIN)	48	72	64	80	69	80	54	47	68	62	82	75	63	61	52	70	79	53	62	47	66	59	53	67	71	62	79	77	85	61	72	65
12	Are you given enough privacy when discussing your condition or treatment? (National CQUIN)	76	78	83	86	79	86	81	80	78	86	85	89	87	81	75	83	87	80	77	82	84	80	81	79	80	83	87	84	81	81	83	82
13	How many minutes after you use the call button does it usually take before you get the help you need?	87	76	76	68	80	78	67	70	67	72	79	78	60	62	63	64	82	56	66	56	76	72	68	58	66	57	79	66	85	67	73	69
14	Beforehand, did a member of staff explain what would be done during the operation or procedure?	60	89	86	81	74	87	81	81	79	78	87	83	76	81	69	67	85	75	68	80	93	82	76	70	81	83	90	87	85	79	84	81
15	After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	80	63	76	82	81	72	81	75	79	70	77	76	73	74	64	63	78	68	60	69	87	62	63	67	74	76	79	79	81	75	74	75
16	Do you feel you are involved in decisions about your discharge from hospital?	86	74	87	81	78	75	82	75	75	78	76	76	79	73	73	83	80	77	81	73	77	83	76	69	74	84	82	84	83	78	79	78
17	Has a member of staff explain the purpose of the medicines you are to take at home in a way you could understand?	87	85	87	81	77	88	82	75	73	82	90	83	67	73	71	56	77	76	87	77	82	86	77	79	75	69	80	84	82	78	83	80
18	Has a member of staff told you about medication side effects to watch out for when you are at home? (National CQUIN)	76	61	80	69	78	66	63	56	58	67	66	56	48	63	49	36	70	41	63	61	56	48	58	66	61	49	62	80	60	64	60	63
19	Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	74	69	71	72	71	54	69	52	57	63	71	64	72	63	77	81	80	77	87	62	67	73	63	83	83	74	71	66	60	66	71	68
20	Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital? (National	80	68	72	72	71	81	65	55	62	61	77	75	63	72	64	56	77	53	77	69	63	55	78	68	72	75	74	85	78	70	72	71
21	Overall, do you feel you are treated with respect and dignity in the hospital?	86	91	87	91	89	91	91	88	87	88	90	91	89	89	85	90	90	90	85	90	90	90	89	89	89	89	91	89	92	88	90	89
22	Overall, how would you rate the care you are receiving?	74	80	76	80	79	86	80	77	76	78	83	82	77	73	70	75	83	74	70	74	78	75	76	76	79	80	80	82	84	77	79	78
23	Would you recommend this hospital to your family and friends?	69	83	82	83	78	80	88	82	78	78	84	85	86	81	78	86	87	82	78	80	84	82	80	83	82	83	83	84	89	81	83	82
	RTM WARD RATING Average (* - R / ** - A / *** - G)	**	**	**	***	**	***	**	**	**	**	***	***	**	**	*	**	***	**	**	*	***	**	**	**	**	**	***	***	***	**	**	**

Experience

End of Life Care

Why we have chosen this

We continue to work to ensure that when patients die in hospital and their death is expected, they die on the End of Life Care pathway. This is a pathway of care specifically designed to ensure patients die comfortably and with dignity.



Commentary

The above graph shows the percentage of patients dying who were placed on the End of Life pathway. The target has increased from 30% to 38% this year but this continues to be achieved with the exception of January where performance dipped just below target.

Patient user forums continue to take place including partner organisations such as hospices.

A training event took place for consultant and middle grade medical staff to discuss patient communication issues around End of Life Care. This was extremely well attended and further training sessions are to be developed.

Permanent funding has been secured for a dedicated trainer for End of Life Care.

Experience

Patient experience in accident and emergency

Why we have chosen this

For many people, the accident and emergency departments will be their first experience of our hospitals and this may be a difficult time for some people because of the injury they have sustained or sudden onset of illness. This important indicator lets us know what kind of service they received.

> "Everyone I came into contact with was kind, professional and helpful."

Patient Experience Questionnaire	A&E Comparisons After Offset	National Survey 2008	2010 (baseline)	2011 (Overall)
	Sample size:		399	455
	Q1 Were you given enough privacy when discussing your condition with the receptionist?	65	75	81
	Q2 Were you told how long you would have to wait to be examined?	31	37	61
	Q3 While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?	78	75	80
	Q4 Were you given enough privacy when being examined or treated?	90	86	89
	Q5 Do you think the hospital staff did everything they could to help control your pain?	70	97	98
	Q6 Did you feel bothered or threatened by other patients?	95	97	98
	Q8 Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	88	80	68
	Q9 Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	52	59	60
	Q11a Were the doctors kind and helpful whilst you were in the Emergency department?	N/A	85	86
	Q11b Were the nurses kind and helpful whilst you were in the Emergency department?	N/A	85	88
	Q11c Were the receptionists kind and helpful whilst you were in the Emergency department?	N/A	81	85
	Q12 Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?	88	90	91
	Average Score	73.7	77.3	80.6
	Q13 If the need arose, would you recommend this hospital to your family and friends? (Yes Definitely)	N/A	76.7%	97.8%

Commentary

The questionnaires were generated from questions within the 2008 National Emergency Care Patient Experience Survey by the Care Quality Commission. The questions were asked in the same way, and responses calculated using the same analysis processes. The only difference is that they are asked when the patients are in the department, rather than after they have been discharged.

Patients tend to score questions higher when asked real-time at the clinic than retrospectively after discharge so the Real Time Patient Monitoring (RTPM) scores have been offset (-7) before being Red Amber Green (RAG) rated against the 2008 national survey.

100 questionnaires are issued over a two week period every three months. The results can be seen in the chart. The feedback we have received in the recent questionnaires show a significant shift towards positive comments from when we began to collect this data 18 months ago.

Part of the quality improvement work we have undertaken has been to hold patient forums using patient volunteers to better understand their experiences. The patient forums have had a significant effect on the staff involved and seen the implementation of some basic and very useful changes.

External validation

We have celebrated some key achievements in 2011/12 that illustrate our strong commitment to provide patients with the best standards of care possible.

Multi-million pound endoscopy units top rated

The endoscopy units at Calderdale Royal Hospital and Huddersfield Royal Infirmary gained full accreditation within weeks of opening.

Inspectors came to look around the units and awarded the accreditation for five years and highlighted first class areas of care.

In their final report the assessors said the sites should be congratulated on being so patient-focused, innovative and for delivering quality standards.

The assessors singled out the units for their excellent patient-centred service, outstanding cross-site leadership and teamwork and innovation such as the introduction of a pre-assessment process and protected time for nurse training at 15 hours per week.

Divisional director for medicine Dr Ashwin Verma said:

"There has only ever been one focus and that is providing the best care for the patients."

New endoscopy unit at Calderdale Royal Hospital

Case Study 3: National recognition for radiology

The radiology departments at our Trust became only the fourth NHS facility in the country to be awarded a prestigious national accreditation. The departments work across both main sites as well as out in the community. They deliver X-ray, ultrasound, fluoroscopy, CT (computered tomography), MRI (Magnetic Resonance Imaging) as well as other medical imaging services.

The ISAS (Imaging Services Accreditation Scheme) accreditation was awarded following close inspection of services across all sites that lasted two full days. This included talking at length with patients who have used the services about their experiences.

Paul Stennett, Chief Executive of United Kingdom Accreditation Service (UKAS) said:

"By achieving your ISAS award this demonstrates staff's on-going commitment to delivering high quality patient focused care and driving continuous improvement."

Dr Sarah Gurney, clinical director and consultant radiologist, said:

"Achievement of the ISAS accreditation confirms that we are delivering a high standard of service to our patients and we are delighted to have gained the accreditation.

"The hard work has made a real difference to the department and we are now able to offer patients a better service than ever before. It has been a really worthwhile process."

The ISAS programme focuses on:

- The quality of patient experience.
- Safety.
- Clinical aspects of care.
- Use of resources.

The accreditation process started in 2007 when the Trust was one of the first pilot sites, helping develop the standards and measures used in the assessment, before becoming one of the 'Early Implementers' in 2009.

UKAS, the national accreditation body appointed by Government, delivers and manages ISAS on behalf of The College of Radiographers and The Royal College of Radiologists. UKAS undertake regular monitoring to ensure that the required standards are maintained.

Performance against key national priorities

Area	Indicator	Threshold	Performance (April 11 – March 12)
Safety	Clostridium Difficile	58	33
Safety	MRSA	5	6
Quality	All cancers: 31-day wait for second or subsequent treatment, comprising **either**:		
	surgery	94%	99.5%
	anti cancer drug treatments	98%	99.7%
	radiotherapy	94%	N/A
Quality	All cancers: 62-day wait for first treatment, comprising **either:**		
	from urgent GP referral to treatment	85%	92.7%
	from consultant screening service referral	90%	97.2%
	from urgent GP referral to treatment	86%	92.6%
Patient experience	Referral to treatment waiting times in 23 weeks – admitted	90%	91.5%
Patient experience	Referral to treatment waiting times in 18.3 weeks – non-admitted	95%	99.3%
Quality	All cancers: 31-day wait from diagnosis to first treatment	96%	99.8%
Quality	Cancer: two week wait from referral to date first seen (8), comprising **either:**		
	all cancers	93%	97.5%
	for symptomatic breast patients (cancer not initially suspected)	93%	95.5%
	Aggregated 2 week wait and breast symptomatic	93%	97%
Quality	A&E:		
	Less than 4 hours total time spent in A&E	95%	96.08%
	Average time to initial assessment 95% patients	<15 mins	19 mins
	Average time to treatment decision	<60 mins	45 mins
	Unplanned reattendance rate	<5%	4.9%
	Left without being seen	<5%	2.2%%

Statement from commissioning PCT, LINks, OSCs

Response from NHS Kirklees, Lead Commissioning PCT

We are pleased to receive and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT) and the following statement is presented on behalf of NHS Kirklees, including comments from NHS Calderdale.

The published account is a comprehensive and detailed assessment of quality in 2011/12 and clearly highlights CHFT's priorities for quality improvement for 2012/13.

To the best of our knowledge, through contract monitoring and Clinical Quality Board, 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.

The Quality Account describes the proactive work the Trust has undertaken to address the key quality priorities and we are pleased to note the progress and improvements made particularly around reduction in readmission rates and the implementation of the COPD care bundle.

The progress on reduction of HCAI is a true and honest reflection of the significant energy and investment that the organisation has provided to the HCAI agenda. We will continue to monitor the work to identify the root causes and changes in practice through the Clinical Quality Board.

We are pleased to see the inclusion of Real Time Patient Monitoring (RTPM) of patient experience in the Quality Account. However, we expected to see the inclusion of the two national surveys; 2011 Survey of Adult Inpatients and the 2011 Survey of People Attending Hospital Outpatients Department which were published earlier this year, as a priority for the 2012/13 quality improvement work, along with clear actions around what the Trust is doing to improve the patient experience demonstrated in improved outcomes in the national surveys.

We also note that in some areas, whilst there have been some improvements, targets have not been met. These priorities have been continued within the 2012/13 improvement priorities and progress will be monitored through the Clinical Quality Board.

The commissioners note the inclusion of the financial achievement of the 2011/12 CQUINs scheme. We expected to see more detail included within the account of the percentage of achievement and which indicators they achieved along with an overview of the 2012/13 scheme.

Commissioners have noted CHFT's participation in most national clinical audits and national confidential enquiries. We expected to see clearer rationale for non participation in certain audits, i.e. Health Promotion as this may impact on the overall public health work.

We look forward to working with CHFT to achieve their improvement priorities and aspirations for 2012/13.

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

Our major piece of work in 2011/12 has been a review of services for people with dementia. The view of the Scrutiny Panel is that the increase in the population of people with dementia combined with under diagnosis and diagnosis that is not early enough makes dementia services an absolute priority for both NHS Trusts and the Council next year and subsequent years. The review report is now complete and It makes recommendations in the following areas:

- The Butterfly Scheme should be extended to all appropriate wards at Calderdale Royal Hospital and Huddersfield Royal Infirmary.
- The recommendations of the National Audit of Dementia Care in General Hospitals 2011 should be implemented in full and progress reported in the Quality Account.
- The Council, Calderdale and Huddersfield NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust should work in partnership to ensure that services and procedures are in place to maximise discharge from Calderdale Royal Hospital to home or intermediate care, rather than to residential or nursing home placements.

Consequently, I am delighted that you have identified improving the care of patients with dementia as a priority for 2012/13.All the improvement work in this area you identify is important. Our work has also identified making sure that discharge arrangements operate well and on a cross-agency basis is particularly important for patients with dementia. Patients with dementia – on average – experience longer

lengths of stay in acute hospitals than other patients, and I hope that – again on a cross-agency basis - steps are taken to reduce lengths of stay.

Hospital is not the best place to take life-changing decisions such as a move to residential or nursing home care and I am sure that discussions about care for people with dementia will consider whether there are more opportunities for your staff to support people at home after they leave hospital.

We had a very interesting discussion with Ashwin Verma, your Divisional Director for Medicine, about stroke services, at our Scrutiny Panel meeting on 22 February. We were pleased to learn of the progress that has been made over the last two years since a CQC report had judged Calderdale services to be amongst the least well performing PCT areas in the country. Ashwin did tell us that there is still a lot to do and we will be considering stroke services again in 2012/13. Our "effectiveness" priority is therefore stroke services.

Reducing readmission within 30 days is an improvement that requires good and effective partnership working between the NHS and social care services within the Council, and so it is one of your priorities that the Scrutiny Panel will retain a close interest in.

I have mainly restricted my comments in this response to those areas that the Scrutiny Panel considered in the last year. I think it would be very useful for the Scrutiny Panel to consider progress on all the priorities you have identified at a meeting in the autumn and I will suggest to the Scrutiny Panel that this should be included in our work programme. As well as helping the Scrutiny Panel to comment on next year's Quality Account more comprehensively, we may also be able to assist you in delivering your priorities.

Response from Kirklees Council's Wellbeing and Communities Scrutiny Panel

Members of the Panel have carefully reviewed the information contained within the report, and are supportive of the Trust's priorities as set out in the report. The Panel welcomed the Trust's engagement in identifying the quality improvement priorities for 2012/13 earlier in the year. At that point, the Panel did feel that developing care bundles for COPD and heart failure remained a priority and should have been included for 2012/13. The Panel is pleased to see that, whilst this is not being carried forward as a priority, the Trust is committed to continuing work to ensure that care bundles for COPD and heart failure are fully implemented throughout the organisation.

The Panel would like to encourage closer working with scrutiny during 2012/13.

Response from Kirklees Local Involvement Network

Kirklees LINk would like to compliment CHFT on the reporting of their quality accounts as it is a very good report and would like to see the work continued on service user experience and participatory engagement.

Kirklees LINk has had involvement with CHFT in the formation of the policy for pressure ulcers. Kirklees LINk are continuing to progress the implementation of this policy into care homes and would like this to be ongoing work.

Kirklees LINk would like to thank CHFT on the progressive work on reducing pressure ulcers.

The Quality Accounts do not have a glossary on abbreviations used throughout the document.

Response from Calderdale Local Involvement Network

Calderdale LINk was not able to comment on the document owing to reductions in funding.

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 as amended 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 2011/12;
- 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 2011 to May 2012.

  Papers relating to Quality reported to the Board over the period April 2011 to May 2012.

  Feedback from the commissioners dated 18 May 2012.

  Feedback from governors dated 18 April 2012.

  Feedback from LINks dated 18 May 2012.

  The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 25 August 2011;

  The 2011 national patient survey 24 April 2012.

  The 2011 national staff survey 19 March 2012.

  The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2012.

  CQC quality and risk profiles dated 30 September 2011, 25 October 2011, 30 November 2011, 31 January 2012 and 2 April 2012.

- 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.monitor-nhsft.gov.uk/annualreportingmanual as well as the standards to support data quality for the preparation of the Quality Report available at www.monitor-nhsft.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

29 May 2012 .....Date.....  .....Chairman

29 May 2012 .....Date.....  .....Chief Executive

Independent Auditor's Report to the Membership Council of Calderdale and Huddersfield NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Membership Council of Calderdale and Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

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

Respective responsibilities of the Directors and auditors

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

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for my report if I became aware of any material omissions.

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

- Board minutes for the period April 2011 to May 2012.
- Papers relating to quality reported to the Board over the period April 2011 to May 2012.
- Feedback from the Commissioners - May 2012.
- Feedback from Governors – April 2012.
- Feedback from Kirklees LINk – May 2012.
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 - August 2011.
- The 2011 national patient survey.
- The 2011 national staff survey.
- Care Quality Commission quality and risk profiles - September 2011 to April 2012; and
- the Head of Internal Audit's annual opinion over the Trust's control environment for the year ended 31 March 2012.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Association of Chartered Certified Accountants (ACCA) Code of Ethics and Conduct. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Membership Council of Calderdale and Huddersfield NHS Foundation Trust as a body, to assist the Membership Council in reporting Calderdale and Huddersfield NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Membership Council to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Membership Council as a body and Calderdale and Huddersfield NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of my assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Calderdale and Huddersfield NHS Foundation Trust.

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

John Prentice – Engagement Lead

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

29 May 2012

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, or require this document in an alternative format, 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 (HRI) has made massive inroads into reducing its carbon emissions with the conversion from a coal fired boiler to a gas-fired state-of-the-art energy centre system thus reducing carbon emissions by a third. This conversion has resulted in a reduction in heavy transport delivering coal to HRI (2 – 3 times weekly) and the collection of ash weekly and a cleaner environment for the site and neighbours.

Other initiatives have contributed to our carbon emissions including:

- Energy efficient lighting (LED – light emitting diodes).
- Replacement windows.
- Local energy controls and metering.
- Heat exchange units.
- Significant reduction in waste sent to landfill due to improved segregation and alternative treatment.
- Recycling of aluminium, paper, cardboard, plastics.
- Raising staff/public awareness via Climate Change Week.
- Monitor the usage of our transport services between our two hospital sites and trialling electric vehicles for our transport services fleet.

At Calderdale Royal Hospital (CRH) measures include:

- Replacement of bedpan washers at CRH for more cost effective and efficient equipment.
- Out of hours lighting controls to reduce light levels in circulation spaces such as corridors and lobbies when departments are closed, thereby reducing electricity consumption.
- LED Lighting fitted in A&E X-Ray waiting area, and Costa Coffee to reduce electricity consumption.
- Plant 'Set-Back' controls to reduce heating and electrical consumption on ventilation plant that is not required to run at full capacity out of normal operating hours; primarily theatres, but also Endoscopy, Intensive Care Unit and administration spaces in Block C.
- Reducing our bulk oil storage on site by running the main hospital heating boilers on oil for one day per week. This off-sets the Trust's energy bill in the short term, but also means that when the oil is replaced it will be cleaner, low-sulphur oil which is more environmentally friendly.
- A scheme to replace the ventilation and chiller plant for the Meal Assembly room on site. It is proposed to replace the air handling unit and chillers with the most modern and energy-efficient type available. The work is currently being tendered and is expected to be implemented in the next four months.

New boiler system at HRI

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

	CHFT 2010/2011					
	Emissions Source / Fuel Type	Amount Used	Units	Kg CO^2 per unit*	Tonnes of CO^2	Cost £
Scope 1	Natural Gas	24179781	kWh	0.1836	4439.4	663255
	Coal	22257904.86	kWh	0.347	7723.493	419355
	Diesel	577923	Litres	0.25012	146.22	48412.29395
	Water	234985	M^3	***	***	471481
	Fleet Vehicles	727256.43	kWh		184.0058	81171.9
	Business Travel	***	***	***	***	121057.14
	Expenditure CRC	***	***		***	121057.14
Scope 2	Electricity	23340635	kWh	0.541	12627.28	1996754
				Totals	25120.4	5012059.474

	CHFT 2011/2012					
	Emissions Source / Fuel Type	Amount Used	Units	Kg CO^2 per unit*	Tonnes of CO^2	Cost £
Scope 1	Natural Gas	44928584	kWh	0.1836	8248.888	1,383,669.45
	Diesel	24728	Litres	2.6766	65.9644	17,408.51
	Water	210795	M^3	***	***	427,751.37
	Fleet Vehicles	727256.43	kWh		184.0058	81171.9
	Business Travel	***	***	***	***	1,714,363.56
	Expenditure CRC	***	***		***	121057.14
Scope 2	Electricity	21768926	kWh	0.5246	11419.98	2,050,099.98
				Totals	19918.836	5,795,521.91

Commentary

Costs and CO2

The overall costs have risen. However, the consumption of utilities and carbon produced has reduced.

Equality and Diversity Report

In line with the Equality Act 2010 the Trust needs to demonstrate having paid due regard to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010;
- Advance equality of opportunity between people from different groups; and
- Foster good relations between people from different backgrounds.

This legislation applies to both services delivered to patients and the employment of staff who identify with the following protected characteristics:

- Age
- Disability
- Race
- Sex
- Sexual orientation
- Gender reassignment
- Marriage or civil partnership
- Pregnancy and maternity
- Religion or belief

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 gender, race, disability, age, sexual orientation, religion or religious/ philosophical belief or marital status.

Specialist services have undertaken specific consultation with groups such as those representing people with learning disabilities, visual impairment, hearing impairment etc.

The Trust has well established relationships with inter faith forums, equality forums, disability partnerships, and sexual orientation networks.

Comments from communities of special interest indicated that they would like the Trust to focus on areas of improvement that fall broadly into three categories and specific evidence is therefore collated under these headings:

- Access
- Information and communication
- Staff attitude, behaviour and training

Staff engagement is supported by Staff and Management Partnership Forums at both Corporate and Divisional levels. Well established and robust organisational development and leadership programmes ensure that staff consultation and involvement is integral to any proposed service changes. Additional staff support is given through an accredited Occupational Health service, staff health and well being programmes and supportive policy frameworks such as mediation.

Staff awareness of Equality and Human Rights issues is covered by the mandatory annual risk management training. In addition 'Embracing Diversity' courses are provided in house for staff through trained facilitators.

In 2011 the Trust commissioned specific 'Deaf Awareness' training. A training package for visual impairment is being piloted.

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

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

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

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

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

Further information on evidence related to the areas listed, right, can be accessed via the Trust website 'Equality and Human Rights' button.

- Employment
- Age – Younger people
- Age – Older people
- Visual impairment
- Hearing impairment
- Physical impairment
- Learning disability
- Mental health
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage or civil partnership

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

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

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

Anybody wishing to contact the Trust for further information or who would like to contribute to the equalities work should e-mail equalityanddiversity@cht.nhs.uk

Staff Survey Report

Staff engagement

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

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

Formal engagement with staff side representatives takes place through the Staff Management Partnership Forum which meets on a monthly basis and the Medical and Dental Pay and Conditions Committee. Our "Strategy to Save Jobs" 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.
- 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 over 10 years and will continue to adopt the principles of the Standard to support its people management processes. The Investor in People Standard is a nationally recognised business improvement tool.

The Trust has in place a workforce health and wellbeing strategy, aiming to influence improvements which impact positively on the health and wellbeing of all of our staff.

The wellbeing of our staff is important to ensure that we continue to provide high quality patient care, supported by good management practices and engage staff in key decisions which affect their health and wellbeing.

A part of our strategy is to identify workload pressures in an attempt to avoid or manage work-related stress. This is co-ordinated by a series of staff engagement events to ensure staff have the opportunity to express their views and opinions about their work and working environment.

This complements the work we do in support of the annual national NHS Staff Survey, where we gather the views of our staff as a means to ensure we are a successful provider of services and a good employer.

The Trust has to constantly adapt to the changing needs of our patients and undertake service reviews to meet these needs. Our staff are involved at all stages of this process.

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 2011 a random sample of 820 members of staff were asked to fill in the survey and 491 responded (60%).

Where we are improving

The results of the staff survey in 2011 have shown that we have made a significant improvement in supporting our staff; they tell us that their job satisfaction is high (best 20% in 2011 – worse than average in 2010); they feel supported by their immediate managers (best 20% in 2011 - worst 20% in 2010); and our score for providing equal opportunities for their career progression and promotion is now in the best 20% category (worse than average in 2010). We have maintained our highest 20% position in regard to offering staff flexible working options to enable them to manage their work/life balance. We have also been working to reduce our work-related stress levels and have improved our score from worst 20% to average. We will continue to support our staff and managers in these areas as part of our health and wellbeing strategy.

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

As part of our modernisation agenda, the Trust continues to develop its approach to dealing with workplace conflict issues such as grievances, harassment and bullying. The Trust now has a focus on mediation as an alternative to formal processes. A number of key Trust staff have been trained and are operating as accredited workplace mediators. Middle and junior managers will be trained during 2012 to supplement their existing skills in handling workplace conflict.

Staff Survey Report

Summary of Performance

	2010/11		2011/12		
Reponse rate	CHFT	National average for acute trusts	CHFT	National average for acute trusts	Trust Improvement
	53%	52%	60%	52%	Increase of 8%

	2010/11		2011/12		Trust Position
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Position
KF16: Percentage of staff receiving health and safety training in last 12 months	81%	80%	75%	81%	Decrease of 6%
KF12: Percentage of staff appraised in last 12 months	84%	78%	77%	81%	Decrease of 7%
KF36: Percentage of staff having equality and diversity training in last 12 months	42%	41%	41%	48%	Decrease of 1%
KF1: Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver	70%	74%	72%	74%	Increase of 2%

Top 4 Ranking Scores	Trust	National Average	Trust	National Average	
KF37: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion	89%	90%	94%	90%	Increase of 5%
KF9: Percentage of staff using flexible working options	67%	63%	67%	61%	No change
KF21: Percentage of staff reporting errors, near misses or incidents witnessed in the last month	95%	95%	98%	96%	Increase of 3%
KF27: Perceptions of effective action from employer towards violence and harassment	3.53	3.56	3.66	3.58	Increase of 0.1 points

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. A staff feedback and action plan will be agreed by the strategy group and published on the staff intranet.

We are fully committed to promoting safe working practices and safe working environments for our staff and patients. We are continuously listening to our staff and taking action to address health and well-being issues.

Regulatory Ratings Report

	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

	Annual Plan 2011/12	Q1 2011/12	Q2 2011/12	Q3 2011/12	Q4 2011/12
Financial risk rating	3	3	3	4	4
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 2011 to 31 March 2012 was as follows:

Board Member	Position	Tenure Review Date *
Andrew Haigh	Chairman – appointed 7.7.11 (previously held the position of NED from 1.12.10)	3 years office expires on 6.7.14
Carol Clark	Non-Executive Director/Vice-Chair and Senior Independent Director, Acting Chair 1.4.11 to 7.7.11	3 years office expired on 30.11.11
Alison Fisher	Non-Executive Director Vice Chair from 1.12.11	3 years office expires on 30.9.12
Jane Hanson	Non-Executive Director and Audit Chair. Senior Independent Non Executive Director from 1.12.11	3 years office expires on 30.9.14
Bill Jones	Non-Executive Director	3 years office expires on 30.11.12
Peter Roberts	Non-Executive Director	3 years office expires on 22.9.14 Appointed 23.9.11
David Anderson	Non-Executive Director	3 years office expires on 22.9.14 Appointed 23.9.11
Jan Wilson	Non Executive Director	3 years office expires on 30.11.14 Appointed 1.12.11
		Appointment Date
Diane Whittingham	Chief Executive	1.4.97 to 31.3.12
Helen Thomson	Director of Nursing/Deputy Chief Executive	1.4.93
Mark Brearley	Director of Finance	1.10.05 to 1.5.11
Keith Griffiths	Director of Finance	25.7.11
Yvette Oade	Medical Director	2.7.07 to 2.10.11
David Wise	Medical Director	3.10.11
Lesley Hill	Director of Service Development	2.5.06
Julie Hull	Director of Personnel & Development	1.9.95
Jonathan Webb	Acting Director of Finance	1.5.11 to 24.7.11

* In accordance with 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, six Non-Executive Directors and six Executive Directors. The Board considers each of the Non-Executive Directors to be independent in character and judgement and have identified no relationships or circumstances that are likely to affect or appear to affect their judgement. Our Non-Executive Directors were appointed because of their experience and specific skills and their strong links with the community. 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. For more information about how the Trust applies the main and supporting principles of the code please see the Annual Governance Statement in the accounts section of this report.

During 2011/12 the Board of Directors met on 12 occasions and attendance at these meetings is given below:

Name	Attendance at Board of Director Meetings 1.4.11 – 31.3.12
Andrew Haigh (Chairman)	09 / 09
Carol Clark	07 / 08
Alison Fisher	08 / 12
Andrew Haigh (NED)	03 / 03
Jane Hanson	10 / 12
Bill Jones	06 / 12
David Anderson	06 / 07
Peter Roberts	03 / 07
Jan Wilson	04 / 04
Diane Whittingham	07 / 12
Helen Thomson	10 / 12
Mark Brearley	01 / 01
Yvette Oade	04 / 07
David Wise	06 / 07
Lesley Hill	10 / 12
Julie Hull	10 / 12
Jonathan Webb	02 / 02
Keith Griffiths	09 / 09

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 347186** or Email: **kathy.bray@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 was acting interim chief executive in East Lancashire Hospitals Trust from 2009 - 2011.

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 was 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 (until May 2011)

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.

Mark left the Trust on 1 May 2011 to take up post as Chief Executive at East Lancashire Hospitals NHS Trust.

Keith Griffiths · Director of Finance (from July 2011)

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

Keith joined the NHS graduate financial management team after leaving Bradford University in 1986. He qualified in 1991 and was appointed finance director of Walton Centre, in Liverpool in 1995 and also acting chief executive there.

During a career break he travelled to South America, New Zealand, Australia, China and North America.

When he returned he joined East Cheshire Hospitals in Macclesfield as finance director then moved to Wrightington, Wigan and Leigh.

Away from work he is interested in classic cars (driving them not mending them!) and snowsports including snowboarding.

Yvette Oade · Medical Director (until October 2011)

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 was the first woman medical director at the Trust. She left the Trust on 2 October 2011 to take up post as Medical Director at Hull and East Yorkshire Hospitals NHS Trust.

David Wise · Medical director (from October 2011)

David Wise joined the Trust in 1994 as a consultant orthopaedic surgeon. He became divisional director in 2001 and associate medical director in 2004 and was appointed medical director in October 2011.

His particular specialty is shoulder surgery.

He is a former pupil of Huddersfield New College and attended Leicester Medical School with specialist training in the Yorkshire Region.

He is married to a GP with two children. He continues as a surgeon alongside his role as medical director. Away from medicine he is a keen sportsman enjoying golf, tennis and skiing.

Lesley Hill · Director of Service Development

Lesley has 24 years' experience as both a healthcare practitioner and manager. She entered health service management following a period as a community pharmacist and having completed an MBA at Cranfield School of Management. She then worked in a variety of business manager, contracts manager and general manager roles at Northwick Park Hospital in Harrow.

Lesley became Head of Acute Commissioning for Bradford Health Authority in 1998, with a specific remit to help them sort out their waiting list and patient access problems, and deliver modernised services. In 2000 Lesley became the director of commissioning and deputy chief executive for North Bradford Primary Care Trust. Lesley was acting chief executive of North Bradford and Airedale Primary Care Trust 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.

Andrew Haigh · Chairman

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. He became Chairman of CHFT in July 2011.

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.

Carol Clark · Vice-chair and Senior Independent Non-Executive Director (until November 2011)

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. Carol left the Trust when her tenure expired on 30 November 2011.

Our Board of Directors

Jane Hanson · Non-Executive Director, Chair of Audit Committee and Senior independent Director

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, Jane joined KPMG and qualified as a chartered accountant where she later became 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.

Jane has held a number of executive director roles including Director of Audit at Aviva in 2002 where in 2004 she was appointed Risk Director responsible for the risk functions, regulatory compliance and a significant portfolio of change programmes in the Life business.

With over 20 years' experience of working at Board level in large and complex organisations Jane now has a portfolio of non-executive director roles including Direct Line Insurance Group and The Reclaim Fund Limited as well as running 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.

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 until 3 January 2010, 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.

Professor Peter Roberts · Non-Executive Director

Peter is Professor Emeritus of Sustainable Spatial Development at the Sustainability Research Institute at the University Of Leeds and also a board member of the Homes and Community Agency and group chair of the First Ark group – which includes a housing association and social enterprises.

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

Nationally and internationally he is involved in a number of activities linked to regional and urban planning, economic development and environmental management. Peter has also acted as an advisor on the House of Commons Childrens, Schools and Families Select Committee.

He has also written many books, reports and papers on urban and regional governance, planning, development, regeneration and management.

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

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

Jan Wilson · Non-Executive Director

Jan has a background in strategic planning, commissioning and inspection in health and social care services. She has a management qualification and worked for Kirklees and Calderdale local authorities.

She has also worked in the West Midlands and North West region implementing the NHS and Community Care Act and the Children's Act.

She was a non-executive director with the former Calderdale and Kirklees Health Authority, deputy chair at South West Yorkshire Mental Health Trust and was senior independent director when it became South West Yorkshire Partnership NHS Foundation Trust (SWYFT).

Current positions include lay chair for junior doctor training with Yorkshire and Humber Post Graduate Deanery, non executive director at Groundwork, Wakefield, associate hospital manager at SWYFT and ambassador for public appointments with the Government Equalities Office.

Jan has three sons and lives in the Holme Valley.

Dr David Anderson · Non Executive Director

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

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

David was brought up in West Yorkshire and has lived in Halifax and Huddersfield since 1980. He is married to a health visitor and has three children. He enjoys cycling, running and tennis.

David is committed to developing and delivering services in Calderdale and Huddersfield and recognises the benefits of more integration across hospital, primary care and local authority services.

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 and Clerical
12	Ancilliary
13	Nurses and 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 2012)

Constituency	Number of Members
1	595
2	2049
3	1291
4	506
5	1273
6	746
7	1458
8	2268

Staff members per constituency (as at 31 March 2012)

Constituency	Number of Members
9	356
10	886
11	1437
12	1740
13	1914

Recruiting event.

Our engagement activities in 2011/12

- The role of the Membership Council is to ensure that the Trust responds to the needs and preferences of the local community. A variety of activities are arranged so that Membership Councillors have the opportunity to meet and converse with members of the Trust.
- In order to help share the views and opinions of the Trust's membership, the Membership Council meet formally four times per year. executive directors and non-executive directors also attend these meetings in order to provide strategic updates, and importantly to take questions from Membership Councillors on any Trust issues.
- Membership Councillors are invited to attend and observe Board of Director meetings, which are held monthly.
- A joint workshop between the Board of Directors and Membership Council is held annually. This event is an important opportunity for Board members to understand the views of Membership Councillors and members. Membership Councillors are also involved in helping the Board to shape future plans.
- In order to have an efficient and effective Membership Council meeting, Membership Councillors who chair Divisional Reference Groups meet quarterly with the Chairman of the Board. This "Chairman's Information Exchange" helps to keep both the Chairman and Membership Councillors up to date with key Trust priorities and issues.
- The Trust is organised into five divisions, four clinical and one corporate. In order for Trust staff and Membership Councillors to engage directly with each other, a series of Divisional Reference Group meetings are held. Each Divisional Reference Group meeting discusses divisional business planning, divisional priorities and any service developments.
- Each Divisional Reference Group is chaired by a Membership Councillor who, along with the other chairs, meet the Trust Chairman at the quarterly Information Exchange.
- The Trust has successfully completed a range of major service developments this year. Membership Councillors have worked closely with clinical colleagues to ensure their success. Instances include the national accreditation of radiology services; the development of two new endoscopy units; and the tendering and outsourcing of the Trust's outpatient pharmacy service.
- Membership Councillors have acted as a 'fresh pair of eyes' in their participation in the annual Patient Environment Action Team (PEAT) inspection visits. Observations and comments from Membership Councillors are captured as part of these inspection visits and help to maintain and improve high standards of patient care across the Trust.

Margaret Priest, left, with Javene Robinson and Emma Parker

- Membership Councillors and members are often directly involved with helping to improve the patient experience. Examples of this are involvement in hospital food tasting sessions; and participation in conducting audits concerned with patient privacy and dignity.
- A series of events and activities were organised throughout the year to exchange ideas, gather feedback and help to inform the decision making of the Board of Directors. 'Medicine for Members' is a popular series of evening talks by Trust staff where members learn more about the workings and priorities of the Trust. Members are also involved in our 'Real Time Patient Monitoring' programme. They are trained and developed to conduct a series of structured bedside interviews, the results of which are fed back directly to ward staff and managers. Feedback is also gathered through 'reading panels' where members help to compose and proofread patient information leaflets. Two Trust-wide membership engagement events were also held. Staff from across each of the Trust's divisions presented key achievements and proposed priorities for future developments, whilst members gave their ideas and feedback.

Our Membership and Membership Council

- The Trust held its Membership Council/Board of Directors annual general meeting on September 22 2011. This meeting was part of the annual Trust health fair where staff created displays and exhibits showcasing their work and achievements throughout the year. Board Members and Membership Councillors were able to meet and chat to members at this popular and well attended event.
- Members receive a copy of Foundation News three times per year. Foundation News contains news and features about the work of the Membership Council, membership opportunities and developments to services for patients.

The major actions from April 2011 to March 2012 to increase and improve membership were:

- Face to face recruitment of visitors to both main hospital sites along with display stands and information in reception and restaurant areas
- Attendance at local sixth form college events, and an in-house event aimed at encouraging sixth form students to consider medicine as a career
- Engagement and recruitment of worshippers at a local Sikh temple
- Participation in an awareness raising event about the needs and services for members of the deaf community

Our Membership Council

" Although I have been a member of staff here for over 12 years, I had no idea of the amount of 'behind the scenes' activity that takes place across all the divisions and the extent of the involvement of staff on a variety of working groups or committees. Despite the huge pressures which now face the NHS, it is evident that the Membership Councillors have a genuine desire to contribute to improving the patient experience, and that for all those staff members, this goes above and beyond the 'day-job'."

Mary Kiely, Consultant in Palliative Medicine, staff elected Membership Councillor

" Membership Councillors act as a bridge between members and the Trust to ensure that members are aware of areas of development which affect patients and that their views are heard. The Trust involves Membership Councillors, takes their role seriously and deals with matters in a positive and transparent way. Being a Membership Councillor is rewarding, and allows you to contribute to improvement of patient services."

Jan Roberts, publically elected Membership Councillor

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 plus the Annual General Meeting. 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
- 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

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

Elected Council Members Elections were held in four public constituencies during 2011 and the results were announced at the Annual Members' Meeting in September 2011. The elections were held under the independent scrutiny of the Electoral Reform Services.

There have been four formal meetings of the Membership Council during 2011/12 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 2011/12
Public			
Bernard Pierce	1	2013 (2nd term)	2 / 4
Kimberley Cooper	1	2014	3 / 3
Frances Macguire	1	2011	0 / 2
Linda Wild	2	2014 (2nd term)	2 / 4
Harjinder Singh Sandhu	2	2013	4 / 4
Peter Middleton	3	2014	3 / 3
Wendy Wood	3	2013	4 / 4
Christine Breare	4	2014 (2nd term)	4 / 4
Vera Parojcic	5	2013	2 / 4
Lisa Herron	5	2013	4 / 4
Peter Naylor (Deputy Chair 1.10.08 - 24.10.11)	6	2012 (2nd term)	4 / 4
Sarah Slade	6	2014	2 / 3
Dot Rayner	7	2011	2 / 2
Liz Breen	7	2011	0 / 2
Liz Schofield	7	2014	2 / 3
Jeannine Hind	7	2014	2 / 3
Jan Roberts	8	2012 (2nd term)	3 / 4
Janette Roberts (Deputy Chair 24.10.11 to present)	8	2013 (2nd term)	1 / 4
Staff			
Paul Knight	9	2011	1 / 2
Mary Kiely	9	2014	2 / 3
Joanna Birch	10	2012	3 / 4
Sue Burton	11	2012	2 / 4
Liz Farnell	12	2012	3 / 4
Chris Bentley	13	2012	4 / 4
Chris Burton	13	2011	1 / 2
Julie Couldwell	13	2011	4 / 4
Stakeholders			
Sue Bernhauser	University of Huddersfield	2012 (2nd term)	2 / 4
Sally McIvor	Kirklees Metropolitan Council	2013	1 / 4
Jan Giles	NHS Kirklees	2014	2 / 4
Helena Corder (Resigned 30.6.11)	NHS Kirklees	2012 (2nd term)	0 / 1
Robert Metcalf	Calderdale Metropolitan Council	2014	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 347186** or email: **kathy.bray@cht.nhs.uk.**

If you would like to get in touch with a Membership Council member, or would like to find out more about becoming a member or about the services provided by the Trust please contact the membership office on **01484 347342** or email: **membership@cht.nhs.uk** or mail: **The Membership Office, Calderdale and Huddersfield NHS Foundation Trust, Freepost HF2076, The Royal Infirmary, Lindley, Huddersfield, HD3 3LE.**

Audit Committee

The Trust has an Audit Committee which meets at least nine times per 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 Governance Statement. 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 during 2011/12 the Board of Directors extended the invitation to Andrew McConnell to assist the Audit Committee in discharging its duties and take on the role of Independent Member on the Audit Committee; this arrangement continued until 31.10.11. Malcolm Rogers joined the Audit Committee as an Independent Member from 1.11.11 on a one-year term. Malcolm has spent more then 30 years in the banking industry, specialising in risk management.

The non-executive director (and Independent Member) membership and attendance of the Audit Committee for the period 1.4.11 to 31.3.12 was:

Name	Attendance at Audit Committee Meetings 1.4.11 – 31.3.12
Jane Hanson (Chair from 1.2.10)	9 / 9
Bill Jones	3 / 9
Jan Wilson (Appointed 1.12.11)	2 / 2
Andrew Haigh (NED until 7.7.11)	3 / 3
* Alison Fisher	2
* Carol Clark	3
Andrew McConnell (appointed 1.11.08 – 31.10.11 as Independent Member of Audit Committee)	2 / 6
Malcolm Rogers (appointed 1.11.11 to present as Independent Members of Audit Committee)	3 / 3

* = Co-opted members

Nominations Committee

The Nominations Committee for non-executive director appointments is a Sub Committee of the full Foundation Trust Membership Council. The standing membership of the Sub Committee is:

- The Chair of the Trust (or Vice Chair/Acting Chair in relation to the appointment of the Chair).
- One appointed Membership Council Member.
- Three elected Membership Council Members (at least two of whom must be publicly elected).
- The Chief Executive of the Foundation Trust.
- The quorum necessary for the transaction of business will be four members of the Sub-Committee, one of which must be the Chair (or Vice Chair/Acting Chair).

Attendees for advice and committee support:

- Director of Personnel and Development.
- Board Secretary.

The Sub Committee met on three occasions (12 May 2011, 7 July 2011 and 22 July 2011) to discuss the non executive appointments arising in-year. The Sub Committee made the following decisions:

- The offer of a further 12 month term of office to Mr Bill Jones, Non Executive Director to take effect from 1 December 2011 until 30 November 2012.
- The appointment of 3 non executive directors each of whom were offered 3 year appointments as follows:
- Mr David Anderson – appointed 23 September 2011until 22 September 2014.
- Professor Peter Roberts – appointed 23 September 2011 until 22 September 2014.
- Mrs Jan Wilson – appointed 1 December 2011 until 30 November 2014.
- The appointment of Mr Andrew Haigh as Chairman for a period of 3 years with effect from 7 July 2011 until 6 July 2014.

The Nominations Sub Committee commissioned the services of an external recruitment consultancy (Odgers Berndtson) to assist with the recruitment of the non-executive directors.

Name	Attendance at 12.5.11 Nominations Sub Committee	Attendance at 7.7.11 Nominations Sub Committee	Attendance at 22.7.11 Nominations Sub Committee
Mrs Carol Clark (Acting Chair)	✓	N/A	N/A
Mr Andrew Haigh (Chairman – appointed 7.7.11)	N/A	✓	✓
Mrs Chris Breare	✓	✓	✓
Mrs Linda Wild	✓	✓	✓
Mrs Sue Bernhauser	✓	✗	✗
Mrs Diane Whittingham	✓	✓	✓

In addition to the formal committee meetings set out in the table above the members of the committee participated in selection processes on 29 June 2011 and 22 July 2011.

Nominations Committee - Executive Directors

The Nominations Committee for Executive Directors is the Board of Directors and in 2011/12 the Board made the following Executive Director appointments:

- Chief Executive.
- Director of Finance.
- Medical Director.

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 upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people. The Trust has well established performance appraisal systems that operate within the Trust's devolved structure

The Sub-Committees of the Membership Council and Board of Directors, which deal with the remuneration, terms of service and contractual arrangements for the non-executive directors and executive directors respectively, operate within well understood and regulated frameworks. The committees receive professional reports in order to inform their decisions and ensure they are evidence based. The reports use pay information derived from the Annual Reports of all Trusts of a similar size and complexity as Calderdale and Huddersfield together with Foundation Trust information, Department of Health guidance and independent advisors. The way in which the committees operate is subject to audit scrutiny.

Remuneration of Non-Executive Directors

The Remuneration and Terms of Service Sub-Committee of the Membership Council sets the remuneration and terms of service for the non-executive directors of the Foundation Trust.

In 2011/2012 the sub-committee met on the 24 May 2011 and 13 March 2012, 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 2011/2012 financial year the members were as follows:

- Mr Peter Naylor, chair, public elected member.
- Mrs Sue Burton, staff elected member.
- Mrs Janette Roberts, public elected member.
- Miss Lisa Herron, public elected member.
- Mrs Wendy Wood, public elected member (from 1.1.12 to present).
- Mrs Jan Giles, nominated stakeholder member (from 1.1.12 to present).
- Mrs Dawn Stephenson, nominated stakeholder member (from 1.1.11 to 1.1.12).

The sub-committee was quorate on each occasion it met and able to conduct its business. The sub-committee reviewed its Terms of Reference and agreed these for the current financial year.

The sub-committee received professional advice from Julie Hull, Director of Personnel and Development.

In 2011/12 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 was presented to the sub-committee at its meeting on 24 May 2011. This enabled the sub-committee to reach an informed decision for the 2010/11 financial year. Internal Audit also conducted a review of the work of the sub-committee and the resulting audit report gave full assurance that the Trust had put in place adequate procedures to ensure that the Remuneration and Terms of Service Sub-Committee was working in accordance with its terms of reference.

Name	Attendance at 24.5.11 Remuneration and Terms of Service Sub Committee for Non Executive Directors	Attendance at 13.3.12 Remuneration and Terms of Service Sub Committee for Non Executive Directors
Mr Peter Naylor (Chair)	✓	✓
Mrs Sue Burton	✓	✓
Mrs Janette Roberts	✓	✓
Miss Lisa Herron	✓	✓
Mrs Wendy Wood	N/A	✓
Mrs Dawn Stephenson	✗	N/A
Mrs Jan Giles	✓	✗

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 five non–executive directors (the non–executive director who chairs the Audit Committee does not sit on the Remuneration Committee).

In the 2011/12 financial year the sub-committee met on two occasions – 17 January 2012 and 16 February 2012.

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 Andrew Haigh, Chair.
- Mrs Alison Fisher, Non-Executive Director.
- Mr Bill Jones, Non-Executive Director.
- Prof Peter Roberts, Non- Executive Director.
- Mrs Jan Wilson, Non-Executive Director.
- Dr David Anderson, Non-Executive Director.

The sub-committee was quorate with five members present at each meeting and was 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, Foundation Trust Network pay data, and IDS Boardroom Pay Reports. In addition the committee received a presentation from external advisers KPMG regarding changes to pensions charges and taxation changes.

The details of salary and entitlements for executive directors are included in the Annual Accounts Note 6.1 and 6.2. 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.

Owen Williams
Chief Executive
29 May 2012

NB – A redundancy payment was made to a senior manager in 2011/12 financial year.

Name	Attendance at 17.1.12 Remuneration Committee for Executive Directors	Attendance at 16.2.12 Remuneration Committee for Executive Directors
Mr Andrew Haigh	✓	✓
Dr David Anderson	✗	✓
Mrs Alison Fisher	✓	✓
Professor Peter Roberts	✓	✓
Mr Bill Jones	✓	✓
Mrs Jan Wilson	✓	✗

Appendix A

Participation in Clinical Audits

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in during 2011/12 are as follows:

Peri- and Neonatal

Audit title	CHFT Eligible for Involvement
Perinatal mortality (MBRRACE-UK)	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
Pain Management (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
Severe Sepsis & Septic Shock (College of Emergency Medicine)	Yes
Adult critical care (ICNARC CMPD)	Yes
Potential donor audit (NHS Blood & Transplant)	Yes
Seizure Management (National Audit of Seizure Management)	Yes

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
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
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No
Liver transplantation (NHSBT UK Transplant Registry)	No
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes
Carotid interventions (Carotid Intervention Audit)	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No

Cardiovascular Disease

Audit title	CHFT Eligible for Involvement
Acute Myocardial Infarction & other ACS (MINAP)	Yes
Heart failure (Heart Failure Audit)	Yes
Acute stroke (SINAP)	Yes
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes

Renal Disease

Audit title	CHFT Eligible for Involvement
Renal replacement therapy (Renal Registry)	No
Renal transplantation (NHSBT UK Transplant Registry)	No

Appendix A

Cancer

Audit title	CHFT Eligible for Involvement
Lung cancer (National Lung Cancer Audit)	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes
Head and neck cancer (DAHNO)	No
Oesophago-gastric Cancer (National O-G Cancer Audit)	Yes

Trauma

Audit title	CHFT Eligible for Involvement
Hip fracture (National Hip Fracture Database)	Yes
Severe trauma (Trauma Audit & Research Network)	Yes

Psychological Conditions

Audit title	CHFT Eligible for Involvement
Prescribing in mental health services (POMH)	No
National Audit of Schizophrenia (NAS)	No

Blood Transfusions

Audit title	CHFT Eligible for Involvement
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	Yes

Health Promotion

Audit title	CHFT Eligible for Involvement
Risk Factors (National Health Promotion in Hospitals Audit)	Yes

End of Life

Audit title	CHFT Eligible for Involvement
Care of Dying in hospital (NCDAH)	Yes

National Confidential Enquiries

Audit title	CHFT Eligible for Involvement
Cardiac Arrest Procedures (NCEPOD)	Yes
Bariatric Surgery (NCEPOD)	Yes
Perioperative Care (NCEPOD)	Yes
Maternal Death Enquiry (CMACE)	Yes
Surgery in children (NCEPOD)	Yes

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust **participated in** during 2011/12 are as follows:

Peri- and Neonatal

Audit title	CHFT participation
Perinatal mortality (MBRRACE-UK)	Yes
Neonatal intensive and special care (NNAP)	Yes

Children

Audit title	CHFT participation
Paediatric pneumonia (British Thoracic Society)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Pain Management (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 participation
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
Severe Sepsis & Septic Shock (College of Emergency Medicine)	Yes
Adult critical care (ICNARC CMPD)	Yes
Potential donor audit (NHS Blood & Transplant)	Yes
Seizure Management (National Audit of Seizure Management)	Yes

Appendix A

Long Term Conditions

Audit title	CHFT participation
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
Adult asthma (British Thoracic Society)	Yes
Bronchiectasis (British Thoracic Society)	Yes

Elective Procedures

Audit title	CHFT participation
Hip, knee and ankle replacements (National Joint Registry)	Yes
Elective surgery (National PROMs Programme)	Yes
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes
Carotid interventions (Carotid Intervention Audit)	Yes

Cardiovascular Disease

Audit title	CHFT participation
Acute Myocardial Infarction & other ACS (MINAP)	Yes
Heart failure (Heart Failure Audit)	Yes
Acute stroke (SINAP)	No
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes

Cancer

Audit title	CHFT participation
Lung cancer (National Lung Cancer Audit)	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes
Oesophago-gastric Cancer (National O-G Cancer Audit)	Yes

Trauma

Audit title	CHFT participation
Hip fracture (National Hip Fracture Database)	Yes
Severe trauma (Trauma Audit & Research Network)	Yes

Blood Transfusion

Audit title	CHFT participation
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	Yes

Health Promotion

Audit title	CHFT participation
Risk Factors (National Health Promotion in Hospitals Audit)	No

Blood Transfusion

Audit title	CHFT participation
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	Yes

National Confidential Enquiries

Audit title	CHFT participation
Cardiac Arrest Procedures (NCEPOD)	Yes
Bariatric Surgery (NCEPOD)	Yes
Perioperative Care (NCEPOD)	Yes
Maternal Death Enquiry (CMACE)	Yes
Surgery in children (NCEPOD)	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 2011/12 are as follows:

Health Promotion

Audit title	CHFT participation	Reason	Projected date of commencement
Risk Factors (National Health Promotion in Hospitals Audit)	No	CHFT has been implementing the exemplar ward programme that covers some of the same areas as this audit and therefore decided to consider participating from a later date.	

Cardiovascular Disease

Audit title	CHFT participation	Reason	Projected date of commencement
Acute stroke (SINAP)	No	CHFT currently evaluating participation in Clinical Information Management System for Stroke (CIMSS), which should support SINAP. Scheduled to take part in SSNAP from April 2012.	

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 2011/12, 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 (MBRRACE-UK)	Yes	100%	100%
Neonatal Intensive and Special Care (NNAP)	Yes	100%	100%

Children

Audit title	CHFT participation	Audit Sample	% Cases submitted
Paediatric Pneumonia (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	Data collection ongoing – deadline 10/04/12
Paediatric Asthma (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	100%
Pain Management (College of Emergency Medicine)	Yes	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	100% or minimum of 20 if 100 cases or more	26 cases submitted
Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	Data collection ongoing – deadline 31/05/12
Non Invasive Ventilation (NIV) - Adults (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	Data collection ongoing – deadline 31/3/12
Pleural Procedures (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	27 cases submitted
Cardiac Arrest (National Cardiac Arrest Audit)	Yes	100%	Ongoing
Severe Sepsis & Septic Shock (College of Emergency Medicine)	Yes	30 per site	100%
Adult Critical Care (ICNARC CMPD)	Yes	100%	100%
Potential Donor Audit (NHS Blood & Transplant)	Yes	100%	100%
Seizure Management (National Audit of Seizure Management)	Yes	30 per site	100%

Long Term Conditions

Audit title	CHFT participation	Audit Sample	% Cases submitted
Diabetes (National Adult Diabetes Audit)	Yes	100%	120 cases submitted
Heavy Menstrual Bleeding (RCOG National Audit of HMB)	Yes	100%	Ongoing
Chronic Pain (National Pain Audit)	Yes	N/A	70 cases submitted
Ulcerative Colitis & Crohn's disease (National IBD Audit)	Yes	40	100%
Parkinson's Disease (National Parkinson's Audit)	Yes	20	100%
Adult Asthma (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	36 cases submitted
Bronchiectasis (British Thoracic Society)	Yes	100% or minimum of 20 if 100 cases or more	37 cases submitted

Appendix 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
Coronary angioplasty (NICOR Adult cardiac interventions audit)	Yes	100%	Data collection ongoing – deadline 03/05/12
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	100%	Ongoing
Carotid interventions (Carotid Intervention Audit)	Yes	100%	100%

Cardiovaascular Disease

Audit title	CHFT participation	Audit Sample	% Cases submitted
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%	100%
Heart failure (Heart Failure Audit)	Yes	100%	Data collection ongoing – deadline 31/05/12
Cardiac Arrhythmia (Cardiac Rhythm Management Audit)	Yes	100%	100%

Renal Disease

Audit title	CHFT participation	Audit Sample	% Cases submitted
Renal replacement therapy (Renal Registry)	Yes	100%	Ongoing

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%	Data collection ongoing – deadline December 2012
Oesophago-gastric Cancer (National O-G Cancer Audit)	Yes	100%	Data collection ongoing – deadline 01/10/12

Trauma

Audit title	CHFT participation	Audit Sample	% Cases submitted
Hip fracture (National Hip Fracture Database)	Yes	Over 100 cases or if less than 100 at least 66%	Over 100
Severe trauma (Trauma Audit & Research Network)	Yes	100%	100%

Blood Transfusion

Audit title	CHFT participation	Audit Sample	% Cases submitted
Bedside Transfusion (National Comparative Audit of Blood Transfusion)	Yes	50	100%
Medical Use of Blood (National Comparative Audit of Blood Transfusion)	Yes	Part 1 - 76	
Part 2 -20% of part 1	97%		

End of Life

Audit title	CHFT participation	Audit Sample	% Cases submitted
Care of Dying in hospital (NCDAH)	Yes	Organisational Audit only	Organisational Audit only

National Confidential Enquiries

Audit title	CHFT participation	Audit Sample	% Cases submitted
Cardiac Arrest Procedures (NCEPOD)	Yes	2	100%
Bariatric Surgery (NCEPOD)	Yes	6	100%
Perioperative Care (NCEPOD)	Yes	13	100%
Maternal Death Enquiry (CMACE)	Yes	100%	100%
Surgery in children (NCEPOD)	Yes	0	NA – No eligible cases

Appendix A

The reports of 21 national clinical audits were reviewed by the provider in 2011/12 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided:

National BTS Asthma Audit

The British Thoracic Society (BTS) national audit assesses compliance with the BTS standards on asthma care. In 2009 the Trust took part in the national audit and proposed a series of improvement work to look into some of the issues highlighted.

The improvement work has now been implemented in the form of an Asthma care bundle. The re-audit carried out in this year's programme has shown that there has been a reduction in admissions compared to the previous audit. Patient Expiratory Flow Rate Recording (PEFR) recording and oxygen saturation measurements have also increased. Further recommendations were put forward following the re-audit and during April 2011 the care bundle was modified several times and ongoing monitoring of its use was carried out. Spot checks of notes and implementation of the care bundle were undertaken by the respiratory team, accompanied by discussion with clinicians to obtain feedback and improve reliability as appropriate. During this time this activity was also accompanied by educational work with a series of 'respiratory workshops' designed for the intake of new doctors, in which the care bundle work and need for improvement in follow-up was discussed and promoted.

National Audit of Carotid Interventions

The Trust takes part in the ongoing national audit on carotid endartectomy which aims to look at the speed of delivery of carotid endartectomy surgery and to assess 30 day mortality and complication rates. This audit compared the Trust's practice between April 2009 to March 2011 against the national report which was published in June 2011.

Over the time period reviewed, 63 operations were carried out with a 0% mortality rate. The audit found that there has been a marked improvement in the speed of surgery over the years.

1.6% of patients suffered a stroke within 30 days of surgery which is lower than the 3% average national figure.

There was a year on year improvement in operations within two weeks of index event, however improvements could be made in this area. One of the main issues for delay in surgery is operation space. The main recommendation from the audit was a dedicated vascular anaesthetist, whom the Trust is in the process of appointing.

National Hip Fracture Database

The British Orthopaedic Association/National Hip Fracture Database sets out six auditable standards: prompt admission to orthopaedic care; surgery within 48 hours; nursing care aimed at minimising the development of pressure ulcers; routine access to ortho-geriatric medical care; assessment and appropriate treatment to promote bone health; and falls assessment. The aim of this audit was to ascertain whether the management of fractured neck of femur patients within the Trust reaches the standards set by the British Orthopaedic Association within the National Hip Fracture Audit.

A high proportion of patients were admitted onto an orthopaedic ward within four hours of presentation and 97% were admitted directly to an orthopaedic ward. 100% of patients who were medically fit received surgery within 48 hours of admission. In relation to bone health, not all patients were assessed to determine their need for antiresorptive therapy (osteoporosis prevention and treatment). The audit also found that a high proportion of patients were discharged with some form of VTE prophylaxis. Overall it was felt that there were good results in relation to admission and operation times. However improvements were needed around bone health assessments. There is some ongoing work around bone health and local osteoporosis guidelines have already been implemented by the orthopaedic department. An Osteoporosis Prevention Group has also been established to improve compliance in the fracture clinic and on the wards.

National Comparative Audit of Blood Transfusion

The 2011 re-audit of Bedside Transfusion Practice specifically addressed two serious risks. These are the risks of misidentifying the patient to be transfused and the risk of the patient experiencing an undetected transfusion reaction. The aim of the audit was to identify poor bedside practice that could potentially result in a serious adverse event related to transfusion. The Trust audited 50 cases across both sites and different specialties.

As a result of the audit a standardised transfusion care plan will be developed in order to provide prompts to prevent omission of critical steps in the transfusion process and improve documentation of observations.

The audit will be repeated annually to check that we are meeting the NHS Litigation Authority transfusion standard.

Other National Clinical Audits the Trust has participated in during 2011/12:

- National Diabetes Inpatient Audit Day
- National Audit of Dementia Care
- National Audit of Cardiac Rehabilitation
- National Clinical Audit Programme for HIV
- National Audit of Multiple Sclerosis
- 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
- National audit of Avascular Necrosis / Bisphosphonate Related Jaw Necrosis (BRONJ)
- Audit of Back Pain Management by NHS Occupational Health Services (Round 2)
- Decreased Conscious Level in Children and Young People
- Child and Adolescent Psychiatry surveillance System Familial Hypercholesterolemia
- Neg Blood Use
- Re-audit of the use of platelets
- National BTS COPD Audit
- National Audit of Asthma Deaths
- Falls and Non Hip Fractures
- Consultant Sign-Off
- National Audit Symptomatic Breast Cancer
- UK National Bariatric Surgery Registry

The reports of 87 local clinical audits were reviewed by the provider in 2011/12 and Calderdale and Huddersfield NHS Foundation Trust is taking the following actions to improve the quality of healthcare provided:

COPD Care Bundle

Patients admitted with acute exacerbation of COPD require a structured hospital admission to minimise length of stay, improve patient outcomes, and reduce the risk of subsequent admission and readmission. Goal based on a number of evidence-based interventions to be undertaken for every patient admitted with COPD (whether on general medical, elderly medical or respiratory ward).

Initially a weekly spot check audit was carried out to test the bundle. Over the coming months this evolved into checking compliance and also raising the profile of the bundle by highlighting potential patients to be placed onto the bundle to medical staff. This seemed to increase the uptake of the bundle and currently the audit involves five case notes per month being audited for bundle compliance.

Appendix A

NICE Guideline on Alendronate, Etidronate, Risedronate, Raloxifene, Strontium Ranelate and Teriparatide for the Secondary Prevention of Osteoporotic Fragility Fractures in Postmenopausal Women (TA161)

Following a number of audits carried out in the Orthopaedic Department regarding bone health protection management (osteoporosis prevention) in the Orthopaedic Department, it was found that compliance with the NICE Guidance was low.

One Orthopaedic Consultant, who is also Osteoporosis Lead, introduced an osteoporosis protocol following the last audit. However, a subsequent re-audit showed that compliance of the guidelines was still fairly low.

As a consequence a Bone Health Prevention Multidisciplinary Group was established to improve compliance. The group brought together all those who could assist in driving through improvements. By using 'small steps of change' the group started to look at ways in which we could improve compliance in the fracture clinic at Huddersfield Royal Infirmary (HRI) before tackling outpatients at Calderdale Royal Hospital and inpatients at HRI.

The group has been successful in changing processes at HRI fracture clinic to ensure bone health protection is considered. Yellow stickers have been added to the Referral To Treatment (RTT) forms and continuation sheets to remind nurses and doctors of the need to consider bone health protection. The preparation team has been trained to identify which patients could have fragility fractures, adding the yellow stickers accordingly.

A recent audit has shown that this process is working well; all patients who had fragility fractures had letters sent back to the GP requesting bone health protection management.

Work is currently underway to improve compliance on the wards (inpatients) at HRI. We have introduced sticker prompts into the 'clerking in' documents to remind doctors to prescribe bone health protection. We are currently auditing the testing of these 'sticker prompts', visiting the wards every day to check to see if the doctors are using the prompts and prescribing. It is hoped that we can include the prompt into the 'clerking in' document permanently.

NICE Clinical Guideline on UTI in children under 5 years (CG54)

Urinary Tract Infection (UTI) is a common bacterial infection causing illness in infants and children. It may be difficult to recognise UTI in children because the presenting symptoms and signs are non-specific, particularly in infants and children under 3 years. NICE introduced guidance for UTI in Children, CG 54 in 2007. This audit was carried out to ascertain adherence to the NICE guideline.

Recommendations from the audit are:

- Ensure urgent microscopy is sent for children <3 months of age
- Improved documentation of urinary symptoms, with clear indication of clinical diagnosis whether upper / lower UTI.
- If suspected upper UTI, treat with antibiotics for a course of 7-10 days, rather than 5 days
- Re-audit after implementation of change with larger sample size.

Biliary Colic

In 2010 a local clinical audit project was undertaken to assess pain management for patients presenting with biliary colic and the timing of laparoscopic cholecystecomy following admission with hepatopancreatobiliary pathology. Pain management was audited against locally agreed standards (based on seven randomised control trials) which suggests Non-Steroidal Anti-Inflamatory Drugs (NSAIDs) are highly effective in the management of patients. The initial audit found that patients presenting with biliary colic were offered opioids rather than Non-Steroidal Anti-Inflamatory Drugs NSAIDs.

The national guidelines on the management of acute pancreatitis state that, patients with biliary pancreatitis should be given definitive management during the same admission, unless a clear definitive treatment plan within two weeks has been made. The 2010 audit found that only one patient (out of 15) had a laparoscopic cholecystectomy in the same admission. The remaining 14 patients were listed for an elective laparoscopic cholecystectomy, with the waiting time ranging from 1 to 4 months.

Following on from the 2010 audit, two recommendations were put forward:

- A protocol be devised for analgesia management for patients with symptomatic and suspected cholelithiasis.
- Specific Confidential Enquiry into Patient Outcome Deaths (CEPOD) lists for laparoscopic cholecystectomies during the acute admission.

It has proved difficult to ensure a dedicated CEPOD list for laparoscopic cholecystectomies due to the variation in numbers from week to week. Instead a biliary colic pathway has been devised and implemented to ensure that appropriate patients are operated on within the same admission.

It is envisaged that work around an analgesia protocol will start in 2012/13.

Antibiotic Audit

Regular ward-based antibiotic audits done by pharmacy consistently show poor compliance with documentation of indication and stop/review dates on antibiotic prescriptions and prompts by ward pharmacists have not led to sustained improvement. There is evidence that inappropriate prescribing can lead to an increase in patient mortality, morbidity, length of stay in hospital, increased risk of healthcare associated infections (C.difficile infection), colonisation with resistant organisms (e.g. MRSA) and have financial implications as well.

This audit aimed to assess the current practice in the prescribing of co-amoxiclav against the Trust antibiotic prescribing policy.

Recommendations from the audit are:

- Consultant microbiologist to gain agreement with respiratory consultants Trust-wide for space in the guidelines for amoxicillin and co-amoxiclav.
- Respiratory consultants to brief their clinical teams.
- Antibiotic pharmacists to draft a list of approved indications for oral co-amoxiclav Trust-wide.
- Antibiotic pharmacists to brief ward pharmacists re results of audit and approved list of indications for co-amoxiclav and ensure ward pharmacists are vigilant in challenging inappropriate prescribing.
- Directorate pharmacists to share audit results and recommendations with their clinical teams.
- Antibiotic pharmacists to continue antibiotic care bundle work with surgical teams at HRI.
- Antibiotic pharmacists to re-start antibiotic care bundle work with respiratory teams at Calderdale Royal Hospital and Huddersfield Royal Infirmary.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10

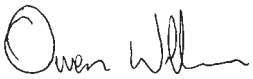
Accounts

for the 12 month period ended 31st March 2012

Accounts

Foreword to the Accounts

These accounts, for the year ended 31 March 2012, 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



Name: Owen Williams (Chief Executive)
Date: 29 May 2012

National Health Service Act 2006

Directions by monitor in respect of National Health Service Foundation Trusts' 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 accounts of an NHS foundation trust for the period from authorisation until 31 March;

or

for an NHS foundation trust in its second or subsequent operating period following authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March.

"the NHS Foundation Trust" means the NHS Foundation Trust in question.

2. Form of accounts

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

(2) The accounts shall meet the accounting requirements of the 'NHS Foundation Trust Annual Reporting Manual' (FT ARM) as agreed with 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 Annual Governance Statement shall be signed and dated by the chief executive of the NHS foundation trust.

3. Statement of accounting officer's responsibilities

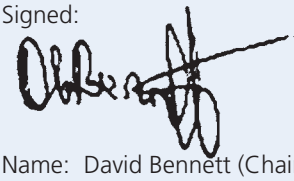
(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

4. Approval on behalf of HM Treasury

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

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

Signed:



Name: David Bennett (Chairman)

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.

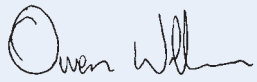
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- 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.

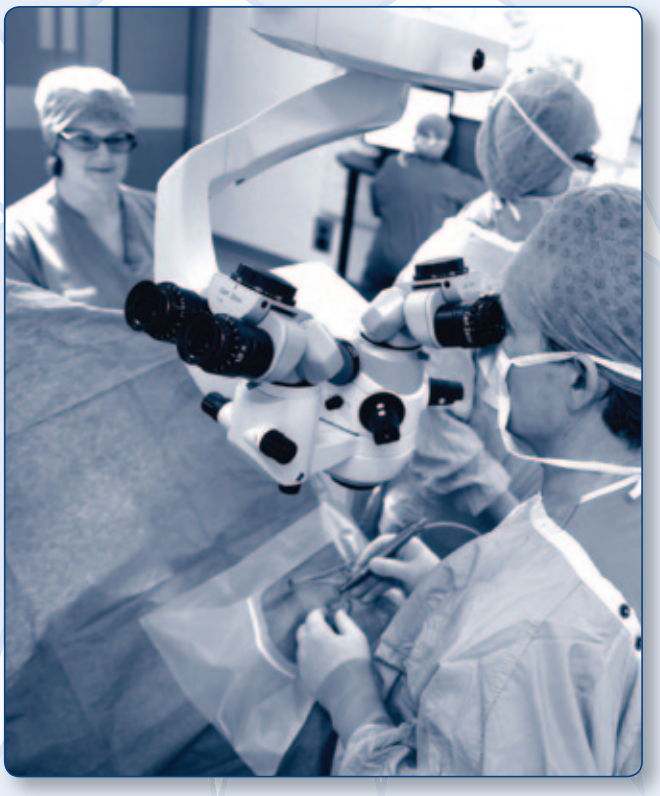
The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting 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: Owen Williams (Chief Executive)
Date: 29 May 2012



Annual Governance Statement

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 and Huddersfield NHS Foundation Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

As Chief Executive, I recognise that committed leadership in 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 Women & Families
- Medicine
- 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 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.

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

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.

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.

Annual Governance Statement
(continued)

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 Trust's Data Encryption and Protection Policy. A number of policies and supporting staff guidance materials set the parameters and expectations around the safe and secure handling and transfer of confidential information.

More widely, the Information Governance Toolkit work programme is led and monitored by the Trust's 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 Trust's induction programme and ongoing mandatory risk training programme. Progress with information governance compliance is measured on a yearly basis through the Trust's self assessment against the Connecting for Health Information Governance Toolkit

"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
Healthcare acquired infections 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 bacteraemias and C Difficile in 2011/12 and 2012/13, which provides a challenge.	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.	2011/12: MRSA - 6: C.Difficile - 33.
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.
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.	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.

continued overleaf >

The organisation's major risks *(continued)*

Risk	Mitigating actions	Outcome measures
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. Calderdale and Huddersfield NHS Foundation Trust clinical strategy for the next 5 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.

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.

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 receives 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.

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 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, 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 its objectives to protect patients, staff the public and other stakeholders against risks of any kind. This allows the Board to support me in signing this Annual Governance Statement.

Responsibility for the effectiveness of organisational systems rests with the Board of Directors which is informed regarding risk by its Governance sub-committees and the Audit Committee. The Board of Directors receives monthly performance and financial management reports as the primary mechanism for assessing compliance with national and local targets, and the identification of existing and potential risks. The Board also receives and endorses key internal and external reports that specifically demonstrate the adequacy of the internal control function in designated risk areas, alongside generic reviews of the Assurance Framework.

The Quality 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, and 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 an encrypted laptop computer and an unencrypted memory stick which were stolen from a locked office at Huddersfield Royal Infirmary. The memory stick contained a password protected spreadsheet containing personal information of up to 270 patients. The police have actively investigated and have arrested and charged a suspect, who the Crown Prosecution Service has agreed to prosecute. The suspect denies the offence and so we have not been able to locate the stolen equipment.

The patients have been informed. The incident has been reported to the Information Commissioners Office. Through the usual communication cascade system, staff have been reminded that the use of unencrypted portable devices is a breach of Trust policy.

A security review of the area has been carried out.

The theft was reported as a serious incident in accordance with Department of Health guidance.

The Internal Audit reports issued in the year have generated significant assurance about the effectiveness of the system of internal control. There were, however, two internal audits which resulted in limited assurance opinions. These are:

- Medicine Code - Patient Group Directions (PGD). This audit found areas of non-compliance with the Code stipulations across a range of wards and departments. In particular the review found many instances where individuals supplying medicine to a patient under a PGD, were not actually named on the relevant PGD. In addition, in a number of instances, medicines were being administered in the manner of a PGD where a PGD was not in place or was not up to date.
- Supply Chain Price Increases. This audit noted that the processes for informing the Trust about price increases in common stock areas are not operating effectively. Further work is needed so that the Trust can more easily identify and track significant variances from contractually agreed prices for common stock items.

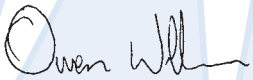
Action plans have been developed to address the necessary improvements, with progress reported to the Audit Committee.

Conclusion

The system of internal control has been in place in Calderdale and Huddersfield NHS Foundation Trust for the year ended 31 March 2012 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



Owen Williams, Chief Executive
Date: 29 May 2012

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 2012 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.

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 Practices 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. In addition, I read all the financial and non-financial 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 as at 31 March 2012 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 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 report to you if, in my opinion, the Annual Governance Statement does not reflect compliance with Monitor's requirements. I have nothing to report in this respect.

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.

John Prentice – Engagement Lead
(Officer of the Audit Commission),
3 Leeds City Office Park, Holbeck,
Leeds, West Yorkshire, LS11 5BD

29 May 2012

Statement of comprehensive income

	Note	2011/12 £000	Restated 2010/11 £000
Operating Income from continuing operations	4	341,260	320,574
Operating Expenses of continuing operations	5	(323,667)	(305,082)
OPERATING SURPLUS / (DEFICIT)		17,593	15,492
FINANCE COSTS			
Finance income	11	215	162
Finance expense - financial liabilities	12	(10,486)	(10,210)
Finance expense - unwinding of discount on provisions		(75)	(59)
PDC Dividends payable		(3,525)	(3,744)
NET FINANCE COSTS		(13,871)	(13,851)
Share of Profit / (Loss) of Associates/Joint Ventures accounted for using the equity method		-	-
Corporation tax expense	10	-	-
Surplus/(Deficit) from continuing operations		3,722	1,641
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations	9	-	-
SURPLUS/(DEFICIT) FOR THE YEAR		3,722	1,641
Other comprehensive income			
Impairments		(4,163)	(19,693)
Revaluations		3,064	4,987
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		-	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		2,623	(13,065)
Prior period adjustment		-	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		2,623	(13,065)
Note: Allocation of Profits/(Losses) for the period:		2011/12 £000	2010/11 £000
(a) Surplus/(Deficit) for the period attributable to:			
(i) minority interest, and		-	-
(ii) owners of the parent.		3,722	1,641
TOTAL		3,722	1,641
(b) total comprehensive income/ (expense) for the period attributable to:			
(i) minority interest, and		-	-
(ii) owners of the parent.		2,623	(13,065)
TOTAL		2,623	(13,065)

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

Operating income for 2011/12 and 2010/11 includes an exceptional item relating to the reversal of impairments on property, plant & equipment of £3,695,000 and £5,680,000 respectively. Operating expenses for 2011/12 and 2010/11 include exceptional items relating to impairments on property, plant & equipment of £969,000 and £5,233,000 respectively.

The surplus positions for 2011/12 and 2010/11, excluding these non-cash exceptional items, are £937,000 and £1,194,000 respectively.

Monitor has adopted the new accounting requirements for government granted assets and donated assets as set out in HM Treasury's 2011/12 FReM. In summary this means the option provided in International Accounting Standard 20 - Accounting for Government Grants and Disclosure of Government Assistance to offset the grants against the cost of the asset has been withdrawn. This also restricts deferral of grant income relating to an asset to income where the funder imposes a condition on the asset. It also requires an identical accounting treatment for donated assets as that for government grants.

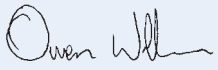
The Trust has no Government Granted Assets or Government Granted Income, but does have some Donated Assets and Donated Income relating to Donated Assets.

The new approach represents a change in accounting policy and the Trust has therefore applied the new policy retrospectively, through a prior period adjustment,therefore restated primary statements for the year ending 31st March 2011 have been included in these accounts in accordance with International Accounting Standard 8 - Accounting Policies, Changes in Accounting Estimates and Errors.

The change has seen a reduction in the Surplus for the 2010/11 of £173,000 from £1,814k to £1,641k.

Statement of financial position

	Note	31 Mar 2012 £000	Restated 31 Mar 2011 £000	Restated 1 Apr 2010 £000
Non-current assets				
Intangible assets	14	**482**	385	281
Property, plant and equipment	15	**206,606**	206,367	217,912
Investment Property		**-**	-	-
Investments in associates (and joined controlled operations)		**-**	-	-
Other investments		**-**	-	-
Trade and other receivables	19	**1,956**	1,736	1,722
Other Financial assets		**-**	-	-
Other assets		**-**	-	-
Total non-current assets		**209,044**	208,488	219,915
Current assets				
Inventories	18	**5,489**	4,727	4,699
Trade and other receivables	19	**10,396**	11,424	13,361
Other financial assets		**-**	-	-
Non-current assets for sale and assets in disposal groups	17	**1,420**	500	-
Cash and cash equivalents	20	**20,306**	15,025	18,237
Total current assets		**37,611**	31,676	36,297
Current liabilities				
Trade and other payables	21	**(26,508)**	(20,887)	(23,248)
Borrowings	22	**(1,771)**	(1,771)	(2,155)
Other financial liabilities		**-**	-	-
Provisions	25	**(2,036)**	(634)	(448)
Other liabilities		**(1,149)**	(3,190)	(1,497)
Liabilities in disposal groups	24	**-**	-	-
Total current liabilities		**(31,464)**	(26,482)	(27,348)
Total assets less current liabilities		**215,191**	213,682	228,864
Non-current liabilities				
Trade and other payables	21	**(457)**	(550)	(633)
Borrowings	22	**(88,758)**	(90,528)	(92,299)
Other financial liabilities		**-**	-	-
Provisions	25	**(3,190)**	(2,299)	(2,562)
Other liabilities	24	**(1,791)**	(1,933)	(1,933)
Total non-current liabilities		**(94,196)**	(95,310)	(97,427)
Total assets employed		**120,995**	118,372	131,437
Financed by (taxpayers' equity)				
Minority Interest		**-**	-	-
Public Dividend Capital		**111,899**	111,899	111,899
Revaluation reserve		**29,786**	31,259	46,435
Available for sale investments reserve		**-**	-	-
Other reserves		**-**	-	-
Merger reserve		**-**	-	-
Income and expenditure reserve		**(20,690)**	(24,786)	(26,897)
Total taxpayers' equity		**120,995**	118,372	131,437

Signed: 

Name: **Owen Williams** · Chief Executive
Date: 29 May 2012

Statement of changes in taxpayers' equity

	Total	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2011	**118,372**	**111,899**	**31,259**	**(24,786)**
Surplus/(deficit) for the year	3,722	-	-	3,722
Transfers between reserves	-	-	-	-
Impairments	(4,163)	-	(4,163)	-
Revaluations	3,064	-	3,064	-
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 movements in PDC in year	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Other reserve movements	-	-	(374)	374
Taxpayers' Equity at 31 March 2012	**120,995**	**111,899**	**29,786**	**(20,690)**

	Total	Dividend Capital	Revaluation Reserve	Assets Reserve	Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2010	**131,437**	**111,899**	**46,059**	**1,543**	**(28,064)**
Prior period adjustment	-	-	376	(1,543)	1,167
Taxpayers' Equity at 1 April 2010 - restated	**131,437**	**111,899**	**46,435**	**-**	**(26,897)**
Surplus/(deficit) for the year	1,641	-	-	-	1,641
Transfers between reserves	-	-	-	-	-
Impairments	(19,693)	-	(19,693)	-	-
Revaluations	4,987	-	4,987	-	-
Receipt of donated assets	-	-	-	-	-
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 movements in PDC in year	-	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-	-
Other reserve movements	-	-	(470)	-	470
Taxpayers' Equity at 31 March 2011	**118,372**	**111,899**	**31,259**	**-**	**(24,786)**

Statement of cash flows

	2011/12	Restated 2010/11
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	17,593	15,492
Operating surplus/(deficit) from discontinued operations	-	-
Operating surplus/(deficit)	17,593	15,492
Non-cash income and expense:		
Depreciation and amortisation	8,998	9,094
Impairments	969	5,233
Reversals of impairments	(3,695)	(5,680)
Interest accrued and not paid	-	-
Dividends accrued and not paid or received	-	-
Amortisation of government grants	-	-
Amortisation of PFI credit	-	-
(Increase)/Decrease in Trade and Other Receivables	846	1,924
Increase/(Decrease) in Other Assets	-	-
(Increase)/Decrease in Inventories	(762)	(28)
Increase/(Decrease) in Trade and Other Payables	3,742	(1,027)
Increase/(Decrease) in Other Liabilities	(2,183)	1,692
Increase/(Decrease) in Provisions	2,293	(77)
Tax (paid) / received	118	21
Movements in operating cash flow of discontinued operations	-	-
Other movements in operating cash flows	774	(167)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	28,693	26,477
Cash flows from investing activities		
Interest received	177	162
Purchase of financial assets	-	-
Sale of financial assets	-	-
Purchase of intangible assets	(208)	(193)
Sales of intangible assets	-	-
Purchase of Property, Plant and Equipment	(7,280)	(14,264)
Sales of Property, Plant and Equipment	5	451
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	(7,306)	(13,844)
Cash flows from financing activities		
Public dividend capital received	-	-
Public dividend capital repaid	-	-
Loans received	-	-
Loans repaid	(562)	(562)
Capital element of finance lease rental payments	-	-
Capital element of Private Finance Initiative Obligations	(1,209)	(1,593)
Interest paid	(298)	(322)
Interest element of finance lease	-	-
Interest element of Private Finance Initiative obligations	(10,201)	(9,900)
PDC Dividend paid	(3,836)	(3,468)
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	(16,106)	(15,845)
Increase/(decrease) in cash and cash equivalents	5,281	(3,212)
Cash and Cash equivalents at 1 April	15,025	18,237
Cash and Cash equivalents at 31 March	20,306	15,025

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 2011/12 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 are 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, additional interim revaluations were undertaken on 31 March 2011 and 31 March 2012 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 is being written off over their remaining useful lives and any new plant and equipment are carried at depreciated historical cost as these are considered to be a reasonable proxy for fair value.

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

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

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

Impairments

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

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

Derecognition

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

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

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

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

Donated assets

Donated and grant funded property, plant and equipment assets are capitalized as their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

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

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

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

Protected assets

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

1.7 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

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

Software

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

Measurement

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

Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment.

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

Amortisation

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

1.8 Government grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost 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 25.3

Non-clinical risk pooling

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

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 25.4 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 25.4, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.14 Public dividend capital

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

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

1.15 Value Added Tax

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

1.16 Corporation Tax

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

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

The Trust entered into a contract from the 1 April with NHS Calderdale to provide community services (with an associated income stream of c.£14m).

Within the notes that follow, this has resulted in increases in other NHS clinical income, in note 4.1, income from Primary Care Trusts in note 4.4, operating expenses in note 5, employee expenses in note 7.1 and average staff numbers in note 7.2.

4 Operating Income

4.1 Operating Income by classification

	2011/12	2010/11
	£000	£000
Income from activities		
Elective income	53,940	52,982
Non elective income	88,883	87,685
Outpatient income	45,747	43,594
A & E income	12,990	11,963
Other NHS clinical income	99,538	81,124
Private patient income	369	383
Other non-protected clinical income	4,781	4,055
Total income from activities	306,248	281,786
Other operating income		
Research and development	1,302	849
Education and training	7,465	7,430
Charitable and other contributions to expenditure	623	502
Transfer from donated asset reserve in respect of depreciation on donated assets		
Non-patient care services to other bodies	8,531	8,531
Other	13,336	15,762
Reversal of impairments of property, plant and equipment	3,695	5,680
Rental revenue from operating leases	60	34
Income in respect of staff costs where accounted on gross basis	-	-
Total other operating income	35,012	38,788
TOTAL OPERATING INCOME	341,260	320,574

4.2 Private patient income

	2011/12	2010/11	Base Year
	£000	£000	£000
Private patient income	369	383	635
Total patient related income	306,248	281,786	174,934
Proportion (as percentage)	0.12%	0.14%	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 2011/12.

4.3 Operating lease income

	2011/12	2010/11
	£000	£000
Operating Lease Income		
Rents recognised as income in the period	60	27
Contingent rents recognised as income in the period	4	7
TOTAL	64	34
Future minimum lease payments due		
- not later than one year;	30	6
- later than one year and not later than five years;	16	16
- later than five years.	28	32
TOTAL	74	54

4.4 Operating Income by type

	2011/12	2010/11
	£000	£000
Income from activities		
NHS Foundation Trusts	1	-
NHS Trusts	239	293
Strategic Health Authorities	112	8
Primary Care Trusts	300,695	276,934
Local Authorities	414	478
Department of Health - other	51	-
NHS Other	-	113
Non NHS: Private patients	369	383
Non-NHS: Overseas patients (non-reciprocal)	-	-
NHS injury scheme (was RTA)	1,968	1,584
Non NHS: Other	2,399	1,993
Total income from activities	306,248	281,786
Other operating income		
Research and development	1,302	849
Education and training	7,465	7,430
Charitable and other contributions to expenditure	623	502
Non-patient care services to other bodies	8,531	8,531
Other *	13,336	15,762
Reversal of impairments of property, plant and equipment	3,695	5,680
Rental revenue from operating leases	60	34
Income in respect of staff costs where accounted on gross basis	-	-
Total other operating income	35,012	38,788
TOTAL OPERATING INCOME	341,260	320,574
Analysis of Income from activities: Non-NHS Other		
Ministry of Defence	-	-
Other government departments and agencies	-	-
Other	2,399	1,993
Total	2,399	1,993

* Other Operating income of £13.3m includes £3.2m estates recharges, £4.1m sales of manufactured pharmaceutical products. and £1.3m catering income (In 2010/11 the comparative figures were £5.7m estates recharges, £3.8m pharmacy sales & £1.3m catering income).

5 Operating Expenses

	2011/12	2010/11
	£000	£000
Services from NHS Foundation Trusts	236	138
Services from NHS Trusts	2,018	1,645
Services from PCTs	158	166
Services from other NHS Bodies	2	-
Purchase of healthcare from non NHS bodies	675	1,733
Employee Expenses - Executive directors	935	936
Employee Expenses - Non-executive directors	152	152
Employee Expenses - Staff	212,223	201,269
Drug costs	22,410	20,365
Supplies and services - clinical (excluding drug costs)	27,228	24,601
Supplies and services - general	2,874	4,316
Establishment	5,155	4,188
Research and Development	4	-
Transport	834	698
Premises	24,501	19,802
Increase / (decrease) in bad debt provision	622	579
Increase in other provisions *	2,764	79
Depreciation on property, plant and equipment	8,888	9,005
Amortisation on intangible assets	110	89
Impairments of property, plant and equipment	969	5,233
Audit services - statutory audit	68	52
Audit services - regulatory reporting	-	-
Audit services - other services	8	12
Clinical negligence	7,004	6,417
Loss on disposal of land and buildings	-	-
Redundancy	153	-
Loss on disposal of other property, plant and equipment	649	157
Other	3,027	3,450
TOTAL	323,667	305,082

*In the 2010/11 Accounts £79,000 was categorised as Other costs this has now been re categorised as increase in other provisons.

6 Salary and Pension entitlements of senior managers

6.1 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. **(See table facing)**

Note A, A Haigh appointed as Chair 07.07.2011 following the death of S Sharma April 2011

Note B, J Hanson is the Chair of the Audit Committee

Note C, C Clark acted up to the post of Chair until the appointment of A Haigh on 07.07.2011. C Clark then returned to the post of Non-Executive Director until 30.11.2011

Note D, D Anderson and Prof P Roberts appointed 23.09.11

Note E, J Wilson appointed 01.12.11

Note F, The salary details for D Whittingham were shared up until April 2011 between Calderdale and Huddersfield NHS FT and East Lancashire Hospitals NHS Trust based on the time spent on Chief Executive duties.

Note G, J Webb acted up as Director of Finance from 01.05.2011 to 25.07.2011 following M Brearley leaving the post of Director of Finance on 30.04.11 and K Griffiths starting in post on 25.07.11.

Note H, Y Oade in post until 02.10.11 replaced by D Wise on 03.10.11. The salary details disclosed for Y Oade and D Wise are apportioned on an estimate of time spent on management rather than clinical duties.

Name and Title	2011/12				2010/11			
	Salary	Other Remuneration	Golden Hello	Compensation for loss of office	Salary	Other Remuneration	Golden Hello	Compensation for loss of office
	(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
A Haigh Chair (Note A)	35 - 40				0 - 5			
S Sharma Chair (Note A)	0 - 5				45 - 50			
A Fisher Non-Executive Director	10 - 15				10 - 15			
J Hanson Non-Executive Director (Note B)	15 - 20				15 - 20			
W Jones Non-Executive Director	10 - 15				10 - 15			
C Clark Non-Executive Director (Note C)	15 - 20				15 - 20			
D Anderson Non-Executive Director (Note D)	5 - 10							
Prof P Roberts Non-Executive Director (Note D)	5 - 10							
J Wilson Non-Executive Director (Note E)	0 - 5							
D Whittingham Chief Executive (Note F)	190 - 195				130 - 135			
M Brearley Director of Finance (Note G)	10 - 15				140 - 145			
J Webb Acting Director of Finance (Note G)	30 - 35							
K Griffiths Director of Finance (Note G)	100 - 105							
L Hill Director of Service Development	130 - 135				125 - 130			
J Hull Director of Personnel	120 - 125				120 - 125			
Y A Oade Medical Director (Note H)	50 - 55				95 - 100			
D Wise Medical Director (Note H)	50 - 55							
H Thomson Director of Nursing	130 - 135				125 - 130			
Additional disclosure								
Band of the highest paid Director's total remuneration	190 - 195							
Median Total (£'000)	27,424							
Remuneration ratio	7							

Additional disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in Calderdale and Huddersfield NHS Foundation Trust in the financial year 2011/12 was £190k - £195k. This was 7 times the median remuneration of the workforce, which was £27,424.

6.2 Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Real Increase/ (Decrease) in Lump sum at age 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2012 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 1 April 2011 £000	Real Increase/ (Decrease) in Cash Equivalent Transfer Value £000
D Whittingham Chief Executive	5.0 - 7.5	(37.5 - 40)	85 - 90	265 - 270	1,811	1,903	(157)
K Griffiths Director of Finance	2.5 - 5.0	10.0 - 12.5	40 - 45	130 - 135	727	562	146
J Webb Acting Director of Finance	5.0 - 7.5	15.0 - 17.5	20 - 25	60 - 65	594	175	413
M Brearley Director of Finance	5.0 - 7.5	17.5 - 20.0	55 - 60	175 - 180	1,134	910	193
L Hill Director of Service Development	2.5 - 5.0	7.5 - 10.0	35 - 40	110 - 115	624	491	116
J Hull Director of Personnel	0.0 - 2.5	2.5 - 5.0	40 - 45	120 - 125	721	600	101
Y A Oade Medical Director (Note I)	0.0 - 2.5	5.0 - 7.5	30 - 35	90 - 95	583	482	83
D Wise Medical Director (Note I)	2.5 - 5.0	7.5 - 10.0	30 - 35	100 - 105	635	527	90
H Thomson Director of Nursing	0.0 - 2.5	2.5 - 5.0	60 - 65	180 - 185	1,174	1,028	112

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

Note I, The pension benefit details disclosed for Y Oade and D Wise are apportioned on an estimate of time spent on management rather than clinical duties.

Cash Equivalent Transfer Values

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

Real Increase/ (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 22 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.

7 Employee Expenses

7.1 Employee Expenses breakdown

	2011/12	2010/11
	£000	£000
Salaries and wages	172,227	162,569
Social security costs	12,819	12,036
Pension costs - defined contribution plans Employers contributions to NHS Pensions	20,977	19,919
Termination benefits	929	399
Agency/contract staff	6,359	7,282
TOTAL	213,311	202,205

7.2 Average number of employees (Whole Time Equivalent basis)

	2011/12	2010/11
	Number	Number
Medical and dental	505	489
Administration and estates	1,248	1,240
Healthcare assistants and other support staff	1,036	1,035
Nursing, midwifery and health visiting staff	1,601	1,415
Scientific, therapeutic and technical staff	761	768
Bank and agency staff	146	163
TOTAL	5,296	5,110

7.3 Employee benefits

The Trust has not paid any employee benefits in the 2011/12 or 2010/11 financial years.

7.4 Early retirements due to ill health

	2011/12	2010/11
	Number	Number
No of early retirements on the grounds of ill health	3	8
	2011/12	2010/11
	£000	£000
Value of early retirements on the grounds of ill health	288	480

7.5 Staff exit packages

	2011/12	2010/11
	Number	Number
Exit package cost band:		
< £10,000	14	9
£10,000 - £25,000	12	4
£25,001 - £50,000	10	3
£50,001 - £100,000	2	-
£100,001 - £150,000	-	-
£150,001 - £200,000	2	-
Total number of exit packages by type	40	16

	2011/12	2010/11
	£000	£000
Total resource cost	1,123	205

The Trust operated a time-limited 'Mutually Approved Resignation Scheme' (MARS) in 2011/12 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. Two exit packages were voluntary redundancy.

8 Operating expenses - miscellaneous

8.1 Operating leases

	2011/12	2010/11
	£000	£000
Minimum lease payments	2,926	2,603
Contingent rents	-	-
Less sublease payments received*	(6)	(6)
TOTAL	2,920	2,597

* The 2010/11 figure for sublease payments received has been restated to include payments received.

8.2 Arrangements containing an operating lease

	2011/12	2010/11
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,548	2,431
- later than one year and not later than five years;	7,893	6,192
- later than five years.	17,569	3,080
TOTAL	28,010	11,703
Total of future minimum sublease lease payments to be received as the balance sheet date	48	52

8.3 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.

8.4 Audit Remuneration

	2011/12	2010/11
	£000	£000
Taxation services	-	-
IT services	-	-
Internal audit services	-	-
Valuation and actuarial services	-	-
Litigation services	-	-
Recruitment and remuneration services	-	-
Corporate finance transactions	-	-
Other	8	12
TOTAL	8	12

9 Discontinued operations

The Trust had no discontinued operations to disclose in 2011/12 or 2010/11.

10 Corporation Tax

The Trust has assessed that it is not liable for Corporation tax in 2011/12 or 2010/11.

11 Finance income

	2011/12	2010/11
	£000	£000
Interest on bank accounts	215	162
Interest on loans and receivables	-	-
Interest on available for sale financial assets	-	-
Interest on held-to-maturity financial assets	-	-
Other	-	-
TOTAL	215	162

12 Finance costs - interest expense

	2011/12	2010/11
	£000	£000
Loans from the Foundation Trust Financing Facility	285	310
Commercial loans	-	-
Overdrafts	-	-
Finance leases	-	-
Other	-	-
Finance Costs in PFI obligations		
Main Finance Costs	7,281	7,417
Contingent Finance Costs	2,920	2,483
TOTAL	10,486	10,210

13 Impairment of assets

	2011/12	2010/11
	£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	-	19,461
Changes in market price	5,132	5,465
Reversal of impairments	(3,695)	(5,680)
TOTAL	1,437	19,246

14 Intangible assets

14.1 Intangible assets 2011/12

	Total
	£000
Valuation/Gross cost at 1 April 2011	1,058
Additions - purchased	207
Additions - donated	-
Additions - internally generated	-
Impairments	-
Reversal of Impairments	-
Reclassifications	-
Revaluations	-
Transferred to disposal group as asset held for sale	-
Disposals	-
Valuation/Gross cost at 31 March 2012	1,265
Amortisation at 1 April 2011	673
Provided during the year	110
Impairments	-
Reversal of Impairments	-
Reclassifications	-
Revaluation surpluses	-
Transferred to disposal group as asset held for sale	-
Disposals	-
Amortisation at 31 March 2012	783

14.2 Intangible assets 2010/11

	Total
	£000
Valuation/Gross cost at 1 April 2010	865
Additions - purchased	193
Additions - donated	-
Additions - internally generated	-
Impairments	-
Reversal of Impairments	-
Reclassifications	-
Revaluations	-
Transferred to disposal group as asset held for sale	-
Disposals	-
Valuation/Gross cost at 31 March 2011	1,058
Amortisation at 1 April 2010	584
Provided during the year	89
Impairments	-
Reversal of Impairments	-
Reclassifications	-
Revaluation surpluses	-
Transferred to disposal group as asset held for sale	-
Disposals	-
Amortisation at 31 March 2011	673

14.3 Intangible assets financing

	Total
	£000
Net book value	
NBV - Purchased at 31 March 2012	482
NBV - Finance leases at 31 March 2012	-
NBV - Donated at 31 March 2012	-
NBV total at 31 March 2012	482
Net book value	
NBV - Purchased at 31 March 2011 (restated)	385
NBV - Finance Leases at 31 March 2011 (restated)	-
NBV - Donated at 31 March 2011 (restated)	-
NBV total at 31 March 2011	385

14.4 Government grants

The Trust has no intangible assets acquired by government grants.

14.5 Economic life of intangible assets

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

The estimated economic useful life of software is five years.

15 Property, plant and equipment

15.1 Property, plant and equipment 2011/12

	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 2011	239,761	44,014	140,342	4,613	5,038	32,100	120	12,044	1,490
Additions - purchased	8,948	-	2,120	-	4,479	1,216	-	1,118	15
Additions - donated	126	-	-	-	-	126	-	-	-
Impairments	(4,163)	(1,249)	(2,708)	(206)	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	7,633	-	(8,343)	24	-	686	-
Reclassified as held for sale	(920)	(380)	-	(540)	-	-	-	-	-
Revaluations	340	-	138	96	-	33	-	73	-
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	(6,668)	-	(12)	-	-	(5,745)	(14)	(897)	-
Valuation/Gross cost at 31 March 2012	237,424	42,385	147,513	3,963	1,174	27,754	106	13,024	1,505
Accumulated depreciation at 1 April 2011	33,394	-	-	-	-	23,352	120	8,731	1,191
Provided during the year	8,888	-	5,347	104	-	2,037	-	1,290	110
Impairments	969	-	1,045	(76)	-	-	-	-	-
Reversal of impairments	(3,695)	-	(3,695)	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale	-	-	-	-	-	-	-	-	-
Revaluation surpluses	(2,724)	-	(2,696)	(28)	-	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	(6,014)	-	(1)	-	-	(5,120)	(14)	(879)	-
Accumulated depreciation at 31 March 2012	30,818	-	-	-	-	20,269	106	9,142	1,301

15.2 Property, plant and equipment 2010/11

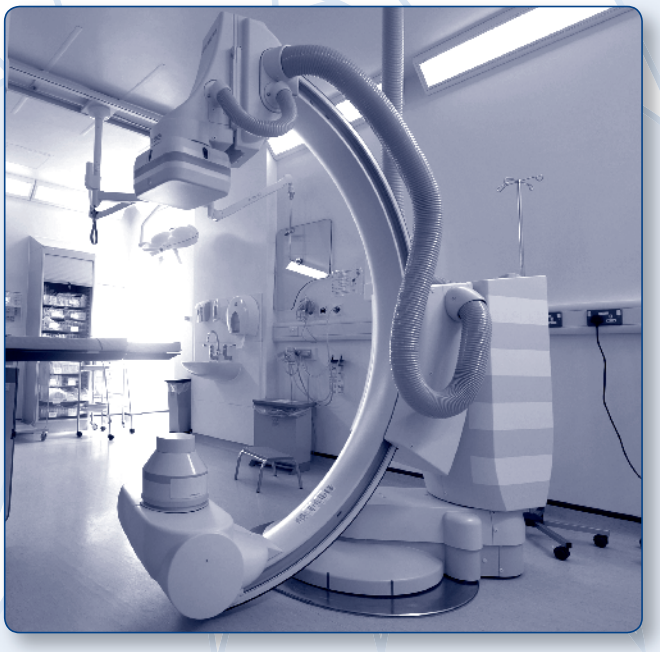
	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2010	251,973	56,689	134,575	5,029	6,276	36,452	132	11,342	1,478
Additions - purchased	12,676	-	3,521	-	8,291	400	-	452	12
Additions - donated	151	-	101	-	-	23	-	27	-
Impairments	(19,693)	(12,275)	(7,398)	(20)	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	100	9,571	(389)	(9,529)	24	-	223	-
Reclassified as held for sale	(500)	(500)	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	(4,846)	-	(28)	(7)	-	(4,799)	(12)	-	-
Valuation/Gross cost at 31 March 2011	239,761	44,014	140,342	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	5,233	-	5,233	-	-	-	-	-	-
Reversal of impairments	(5,680)	(150)	(5,426)	(104)	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Reclassified as held for sale	-	-	-	-	-	-	-	-	-
Revaluation surpluses	(4,987)	150	(5,117)	(20)	-	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-	-	-	-	-	-
Disposals	(4,238)	-	(2)	(1)	-	(4,223)	(12)	-	-
Accumulated depreciation at 31 March 2011	33,394	-	-	-	-	23,352	120	8,731	1,191

15.3 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 2012									
Owned	123,086	41,650	65,576	3,963	1,090	6,741	-	3,862	204
Finance Lease	735	735	-	-	-	-	-	-	-
PFI	81,324	-	81,294	-	30	-	-	-	-
Donated	1,461	-	643	-	54	744	-	20	-
NBV total at 31 March 2012	206,606	42,385	147,513	3,963	1,174	7,485	-	3,882	204
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	1,371	-	403	-	55	887	-	26	-
NBV total at 31 March 2011	206,367	44,014	140,342	4,613	5,038	8,748	-	3,313	299

15.4 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



16 Protected assets

16.1 Analysis of property, plant and equipment 31 Mar 2012

	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 2012	96,974	3,774	93,200	-	-	-	-	-	-
NBV - Unprotected assets at 31 March 2012	109,632	38,611	54,313	3,963	1,174	7,485	-	3,882	204
Total at 31 March 2012	206,606	42,385	147,513	3,963	1,174	7,485	-	3,882	204

16.2 Analysis of property, plant and equipment 31 Mar 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	93,725	3,847	89,878	-	-	-	-	-	-
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	206,367	44,014	140,342	4,613	5,038	8,748	-	3,313	299

16.3 NBV of property, plant and equipment in the revaluation reserve as at 31 Mar 2012

	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
As at 1 April 2011	31,260	28,615	60	1,363	-	1,173	0	-	49
Movement in year	(1,473)	(1,230)	129	(102)	-	(297)	-	71	(44)
As at 31 March 2012	29,787	27,385	189	1,261	-	876	0	71	5

16.4 NBV of property, plant and equipment in the revaluation reserve as at 31 Mar 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
As at 1 April 2010	46,435	41,040	2,467	1,386	-	1,428	0	-	114
Movement in year	(15,175)	(12,425)	(2,407)	(23)	-	(255)	-	-	(65)
As at 31 March 2011	31,260	28,615	60	1,363	-	1,173	0	-	49

17 Assets held for sale

17.1 Non-current assets for sale and assets in disposal groups - 2011/12

	Total	Intangible assets	Property, Plant and Equipment	Financial Investments	Other
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2011	500	-	500	-	-
Plus assets classified as available for sale in the year	920	-	920	-	-
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 2012	1,420	-	1,420	-	-

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

	Total	Intangible assets	Property, Plant and Equipment	Financial Investments	Other
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 31 March 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	-	-

18 Inventories

18.1 Inventories

	31 Mar 2012	31 Mar 2011
	£000	£000
Drugs*	1,997	1,857
Work in progress	221	182
Consumables*	3,271	2,688
TOTAL Inventories	5,489	4,727

*The Inventorories headings have changed from Materials, Work in Progress and finished goods in 2010/11 to the above in line with Monitor guidance.

18.2 Inventories recognised in expenses

	2011/12	2010/11
	£000	£000
Inventories recognised in expenses	49,638	44,966
Write-down of inventories recognised as an expense	-	-
Reversal of any write down of inventories resulting in a reduction of recognised expenses	-	-
TOTAL Inventories recognised in expenses	49,638	44,966

19 Trade and other receivables

19.1 Trade receivables and other receivables

	Total 31 Mar 2012	Restated Total 31 Mar 2011	Original Total 31 Mar 2011
	£000	£000	£000
Current			
NHS Receivables - Revenue*	5,434	5,805	6,552
NHS Receivables - Capital	-	-	-
Other receivables with related parties - Revenue	427	64	60
Other receivables with related parties - Capital	-	-	-
Provision for impaired receivables	(468)	(511)	(511)
Deposits and Advances	-	-	-
Prepayments (Non-PFI)	1,733	2,029	2,029
PFI Prepayments	-	-	-
Prepayments - Capital contributions	-	-	-
Prepayments - Lifecycle replacements	-	-	-
Accrued income *	400	1,164	421
Interest Receivable	38	-	-
Corporation tax receivable	-	-	-
Finance Lease Receivables	-	-	-
Operating lease receivables	-	-	-
PDC dividend receivable	187	-	-
Other receivables	2,645	2,873	2,873
Other receivables - Capital	-	-	-
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	10,396	11,424	11,424
Non-Current			
NHS Receivables - Revenue*	-	-	685
NHS Receivables - Capital	-	-	-
Other receivables with related parties - Revenue	-	-	-
Other receivables with related parties - Capital	-	-	-
Provision for impaired receivables	(136)	(248)	(248)
Deposits and Advances	-	-	-
Prepayments (Non-PFI)	-	-	-
PFI Prepayments	-	-	-
Prepayments - Capital contributions	-	-	-
Prepayments - Lifecycle replacements	-	-	-
Accrued income*	796	685	-
Interest Receivable	-	-	-
Corporation tax receivable	-	-	-
Finance Lease Receivables	-	-	-
Operating lease receivables	-	-	-
VAT receivable	-	-	-
Other receivables	1,296	1,299	1,299
Other receivables - Capital	-	-	-
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	1,956	1,736	1,736

*Monitor require balances with NHS Bodies to be disclosed in more detail in 2011/12. To aid year on year comparison, the 2010/11 comparative for NHS Receivables has been restated in line with new requirements. £747,000 originally categorised as current 'NHS Receivables - Revenue' in 2010/11 has been re-categorised as'Accrued Income' and 'Other receivables related parties - revenue' - £743,000 and £4,000 respectively. £685,000 orginally categorised as non current 'NHS Receivables-Revenue' in 2010/11 has now been re-categorised as non-current ' Accrued Income'.

NHS Receivables falling due within one year includes £2,486,000 for incomplete spells of care provided at 31 March 2012 (£2,541,000 at 31 March 2011).

19.2 Provision for impairment of receivables

	2011/12	2010/11
	£000	£000
At 1 April	759	245
Increase in provision	681	602
Amounts utilised	(777)	(65)
Unused amounts reversed	(59)	(23)
At 31 March	604	759

19.3 Analysis of impaired receivables

	2011/12	2010/11
	£000	£000
Ageing of impaired receivables		
0 - 30 days	19	179
30-60 Days	26	46
60-90 days	36	38
90-180 days (was "In three to six months")	184	116
180-360 days (was "Over six months")	339	381
Total	604	760
Ageing of non-impaired receivables past their due date		
0 - 30 days	1,183	1,566
30-60 Days	413	247
60-90 days	157	179
90-180 days (was "In three to six months")	316	409
180-360 days (was "Over six months")	791	395
Total	2,860	2,796

19.4 Finance lease receivables

The Trust had no finance lease receivables in 2011/12 or 2010/11

20 Cash and cash equivalents

	2011/12	2010/11
	£000	£000
At 1 April	15,025	18,237
Net change in year	5,281	(3,212)
At 31 March	20,306	15,025
Broken down into:		
Cash at commercial banks and in hand	134	129
Cash with the Government Banking Service	20,172	14,896
Other current investments	-	-
Cash and cash equivalents as in SoFP	20,306	15,025
Bank overdraft - Government Banking Service	-	-
Bank overdraft - Commercial banks	-	-
Cash and cash equivalents as in SoCF	20,306	15,025

20.1 Third party assets held by the NHS Foundation Trust

	2011/12 Bank Balances	2011/12 Money on Deposit	2010/11 Bank Balances	2010/11 Money on Deposit
	£000	£000	£000	£000
At 1 April	1	-	3	-
At start of period for new FTs	-	-	-	-
Gross inflows	24	-	27	-
Gross Outflows	(24)	-	(29)	-
At 31 March	1	-	1	-

21 Trade and other payables

21.1 Trade and other payables

	Total 31 Mar 2012	Restated Total 31 Mar 2011	Original Total 31 Mar 2011
	£000	£000	£000
Current			
Receipts in advance	-	1	1
NHS payables - capital	-	-	-
NHS payables - revenue*	1,114	1,603	5,402
NHS Payables - Early retirement costs payable within one year	-	-	-
Amounts due to other related parties - capital	-	-	-
Amounts due to other related parties - revenue*	2,651	2,488	-
Other trade payables - capital	2,825	1,157	1,157
Other trade payables - revenue	6,170	5,742	5,742
Social Security costs	-	-	-
VAT payable	-	-	-
Other taxes payable	4,335	4,124	4,124
Other payables	2,489	1,696	1,696
Accruals*	6,924	3,952	2,641
PDC dividend payable	-	124	124
Reclassified to liabilities held in disposal groups in year	-	-	-
TOTAL CURRENT TRADE AND OTHER PAYABLES	26,508	20,887	20,887
Non-current			
Receipts in advance	-	-	-
NHS payables - capital	-	-	-
NHS payables - revenue	-	-	-
Amounts due to other related parties - capital	-	-	-
Amounts due to other related parties - revenue	-	-	-
Other trade payables - capital	-	-	-
Other trade payables - revenue	-	-	-
VAT payable	457	550	550
Other taxes payable	-	-	-
Other payables	-	-	-
Accruals	-	-	-
TOTAL NON CURRENT TRADE AND OTHER PAYABLES	457	550	550

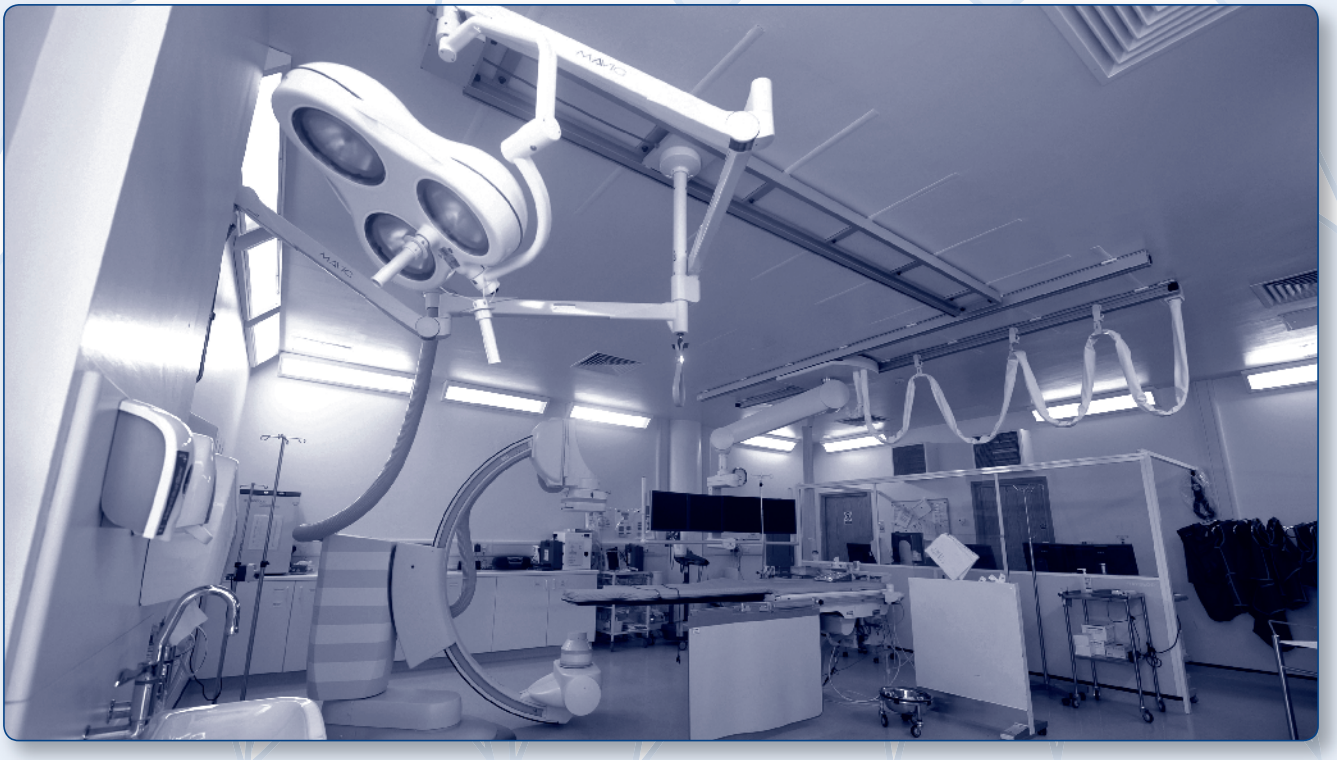
* Monitor require balances with NHS bodies to be disclosed in more detail in 2011/12. To aid year on year comparison, the 2010/11 comparative for NHS payables has been restated in line with these new requirements. £3,799,000 originally categorised as current 'NHS Payables - revenue' in 2010/11 has been re-categorised as 'Amounts due to other related Parties-Revenue' and 'Accruals' - £2,488,000 and £1,311,000 respectively.

21.2 Early retirements detail included in NHS payables above

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

22 Borrowings

	31 Mar 2012	31 Mar 2011
	£000	£000
Current		
Bank overdrafts - Government Banking Service	-	-
Bank overdrafts - Commercial banks	-	-
Drawdown in committed facility	-	-
Loans from Foundation Trust Financing Facility	562	562
Loans from Department of Health	-	-
Other Loans	-	-
Obligations under finance leases	-	-
Obligations under Private Finance Initiative contracts	1,209	1,209
TOTAL CURRENT BORROWINGS	1,771	1,771
Non-current		
Loans from Foundation Trust Financing Facility	5,632	6,194
Other Loans	-	-
Obligations under finance leases	-	-
Obligations under Private Finance Initiative contracts	83,126	84,334
TOTAL OTHER NON CURRENT LIABILITIES	88,758	90,528



23 Prudential borrowing

23.1 Prudential borrowing limit

	2011/12	2010/11
	£000	£000
Total long term borrowing limit set by Monitor (per Schedule 5 of Trust's terms of Authorisation)	92,300	94,500
Working capital facility limit agreed by Monitor (per Schedule 5 of Trust's terms of Authorisation)	22,800	22,800
TOTAL PRUDENTIAL BORROWING LIMIT	115,100	117,300
Long term borrowing at 1 April	92,300	94,456
Net actual borrowing/(repayment) in year - long term	(1,771)	(2,156)
Long term borrowing at 31 March	90,529	92,300
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 £92.3m in 2011/12 (£94.5m in 2010/11) and remained within these limits.

The Trust repaid £562,000 to the Foundation Trust Financing Facility, and repaid £1,209,000 on the PFI Finance Lease Creditor in 2011/12.

The Trust's approved working capital facility limit was £22.8m in 2011/12 (£22.8m 2010/11). The Trust did not use this facility during the 2011/12 or 2010/11 financial years.

23.2 Financial Ratios

	2011/12		2010/11	
	Actual	Approved	Actual	Approved
Financial Ratios				
Minimum dividend cover	4.0x	3.6x	3.8x	3.8x
Minimum interest cover	2.3x	2.3x	2.4x	2.3x
Minimum debt service cover	2.0x	2.0x	2.0x	1.9x
Maximum debt service to revenue	3.6%	3.7%	4.0%	4.0%

24 Other liabilities

	31 Mar 2012	31 Mar 2011	1 April 2010
	£000	£000	£000
Current			
Deferred grants income	-	-	-
Other Deferred income	1,149	3,190	1,497
Deferred PFI credits	-	-	-
Lease incentives	-	-	-
Net Pension Scheme Liability	-	-	-
TOTAL OTHER CURRENT LIABILITIES	1,149	3,190	1,497
Non-current			
Deferred grants income	-	-	-
Other Deferred income	1,791	1,933	1,933
Deferred PFI credits	-	-	-
Lease incentives	-	-	-
Net Pension Scheme Liability	-	-	-
TOTAL OTHER NON CURRENT LIABILITIES	1,791	1,933	1,933

24.1 Other Financial Liabilities

	31 Mar 2012	31 Mar 2011
	£000	£000
Non-current		
Derivative and embedded derivatives held at 'fair value through income and expenditure'	-	-
Other financial liabilities	-	-
Total	-	-
Current		
Derivative and embedded derivatives held at 'fair value through income and expenditure'	-	-
Other financial liabilities	-	-
Total	-	-

25 Provisions and contingent liabilities

25.1 Provisions for liabilities and charges

	Current		Non-current	
	31 Mar 2012	31 Mar 2011	31 Mar 2012	31 Mar 2011
	£000	£000	£000	£000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	262	251	2,058	1,275
Other legal claims	126	148	-	-
Agenda for Change	-	-	-	-
Restructurings	-	-	-	-
Continuing care	-	-	-	-
Equal pay	-	-	-	-
Redundancy	-	-	-	-
Other	1,648	235	1,132	1,024
Total	2,036	634	3,190	2,299

25.2 Provisions for liabilities and charges analysis

	Total	Pensions - former directors	Pensions - other staff	Other legal claims	Redundancy	Other *
	£000	£000	£000	£000	£000	£000
At 1 April 2011	2,933	-	1,526	148	-	1,259
At start of period for new FTs	-	-	-	-	-	-
Change in the discount rate	12	-	-	-	-	12
Arising during the year	2,929	-	1,052	135	-	1,742
Utilised during the year	(643)	-	(262)	(125)	-	(256)
Reclassified to liabilities held in disposal groups in year	-	-	-	-	-	-
Reversed unused	(80)	-	(40)	(32)	-	(8)
Unwinding of discount	75	-	44	-	-	31
At 31 March 2012	5,226	-	2,320	126	-	2,780
Expected timing of cashflows:						
- not later than one year;	2,036	-	262	126	-	1,648
- later than one year and not later than five years;	1,226	-	968	-	-	258
- later than five years.	1,964	-	1,090	-	-	874
TOTAL	5,226	-	2,320	126	-	2,780

*The significant values within Other Provisions of £2.780m relate to provisions of £1.2m for Injury Benefit payments for previous employees of the Trust payable to NHS Pensions Agency, £0.86m relating to potential asset sales shared with other NHS Bodies, £0.36m relating to uncertain operating income and £0.28m to provide for the introduction of the National Carbon Reduction Scheme.

25.3 Clinical Negligence liabilities

	31 Mar 2012	31 Mar 2011
	£000	£000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Calderdale and Huddersfield NHS Foundation Trust	50,948	39,595

25.4 Contingent (Liabilities) / Assets

There were no contingent liabilities or assets to disclose at 31 March 2012 or 31 March 2011.

26 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 2011/12, that all bodies within the scope of 'Whole of Government Accounts' (WGA) are related parties. Accordingly, the table below details material transactions. **(On the page facing)**

Related party transactions - WGA organisations	2011/12 £000	Restated 2010/11 £000	Orginal 2010/11 £000
Income - NHS Calderdale	147,888	130,667	130,667
Income - NHS Kirklees	143,836	140,949	140,949
Income - NHS Bradford & Airedale	8,263	8,173	8,173
Income - NHS Wakefield District	3,117	3,394	3,394
Income - South West Yorkshire Partnership NHS Foundation Trust	4,181	6,674	6,674
Income - Yorkshire & Humber SHA	9,140	9,173	9,173
Income - NHS Pension Scheme	-	-	-
Income - NHS Litigation Authority	5	1	1
Income - HMRC - Taxes & Duties	-	-	-
Income - National Insurance Fund	-	-	-
Income - Other WGA	12,636	11,325	11,325
Income - Total with WGA organisations	329,066	310,356	310,356
Expenditure - NHS Calderdale	982	753	753
Expenditure - NHS Kirklees	280	301	301
Expenditure - NHS Bradford & Airedale	44	74	74
Expenditure - NHS Wakefield District	78	52	52
Expenditure - South West Yorkshire Partnership NHS Foundation Trust	130	107	107
Expenditure - Yorkshire & Humber SHA	27	60	60
Expenditure - NHS Pension Scheme	21,042	19,983	19,983
Expenditure - NHS Litigation Authority	7,202	6,615	6,615
Expenditure - HMRC - Taxes & Duties*	-	-	12,036
Expenditure - National Insurance Fund	12,819	12,036	-
Expenditure - Other WGA	7,642	15,915	15,915
Expenditure - Total with WGA organisations	50,246	55,896	55,896

Related party transactions - WGA organisations	31 March 2012 £000	Restated 31 March 2011 £000	Original 31 March 2011 £000
Receivables - NHS Calderdale	1,812	1,776	1,776
Receivables - NHS Kirklees	1,825	3,155	3,155
Receivables - NHS Bradford & Airedale	377	319	319
Receivables - NHS Wakefield District	301	246	246
Receivables - South West Yorkshire Partnership NHS Foundation Trust	722	493	493
Receivables - Yorkshire & Humber SHA	69	110	110
Receivables - NHS Pension Scheme	-	-	-
Receivables - NHS Litigation Authority	5	1	1
Receivables - HMRC - Taxes & Duties	-	-	-
Receivables - National Insurance Fund	-	-	-
Receivables - Other WGA	1,763	1,232	1,197
Receivables - Total with WGA organisations*	6,874	7,332	7,297
Payables - NHS Calderdale	464	1,798	681
Payables - NHS Kirklees	56	271	118
Payables - NHS Bradford & Airedale	25	36	17
Payables - NHS Wakefield District	80	194	16
Payables - South West Yorkshire Partnership NHS Foundation Trust	122	102	15
Payables - Yorkshire & Humber SHA	449	550	1
Payables - NHS Pension Scheme	2,702	2,549	2,549
Payables - NHS Litigation Authority	1	-	-
Payables - HMRC - Taxes & Duties*	2,331	2,268	4,124
Payables - National Insurance Fund	2,003	1,856	
Payables - Other WGA	2,677	2,848	2,005
Payables - Total with WGA organisations*	10,910	12,472	9,526

* In 2010/11 Accounts, expenditure of £12,036,000 was disclosed as Expenditure - HMRC - Taxes and Duties, this has now been correctly disclosed Expenditure - National Insurance Fund. Receivables - Total with WGA organisations was disclosed as £7,297,000 this has now been correctly disclosed as £7,332,000 and Payables - Total with WGA organisations was disclosed as £9,526,000 and has now been correctly disclosed as £12,472,000.

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 and 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	2011/12 £000	2010/11 £000
Income	623	351
Expenditure	-	-
Related party balances - Calderdale & Huddersfield NHS Foundation Trust Charitable Fund	**31 March 2012 £000**	**31 Mar 2011 £000**
Receivables	76	53
Payables	-	-

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 6).

26.1 Joint Venture

The Trust entered into a joint venture with Henry Boot Development Ltd on 24 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.

The Trust has used the equity accounting method.

There are no contingent liabilities of the JV for which the Trust is jointly and contingently liable.

The JV has no capital commitments

Disclosure of aggregate amounts for assets and liabilities of jointly controlled operations	**31 Mar 2012 £000**	31 Mar 2011 £000
Current assets	-	-
Non current assets	322	-
Total assets	322	-
Current liabilities	(322)	-
Non current liabilities	-	-
Total liabilities	(322)	-
Operating income	-	-
Operating expenses	-	-
Surplus /(deficit) for the year	-	-

27 Contractual Capital Commitments

	31 Mar 2012	31 Mar 2011
	£000	£000
Property, Plant and Equipment	325	1,547
Intangible assets	186	-
Total	511	1,547

27.1 Other Financial Commitments

The Trust is not committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements).

28 PFI (on Statement of Financial Position)

28.1 PFI obligations (on Statement of Financial Position)

	31 Mar 2012	31 Mar 2011
	£000	£000
Gross PFI liabilities	253,805	251,746
of which liabilities are due		
- not later than one year;	11,271	10,830
- later than one year and not later than five years;	44,662	42,734
- later than five years.	197,872	198,182
Finance charges allocated to future periods	(169,470)	(166,203)
Net PFI obligation	84,335	85,543
- not later than one year;	1,209	1,209
- later than one year and not later than five years;	5,636	5,439
- later than five years.	77,490	78,895

28.2 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 2012	31 Mar 2011
	£000	£000
Commitments		
Within one year	9,967	9,542
2nd to 5th years (inclusive)	39,869	38,169
later than five years.	141,202	144,724
TOTAL	191,038	192,435

The PFI scheme above relates to Calderdale Royal Hospital. The PFI contractor is Catalyst Healthcare Ltd. The Trust is responsible for the provision of all clinical services, Catalyst Healthcare Ltd provide fully serviced hospital accommodation.

29 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.

30 Financial assets and financial liabilities

30.1 Financial assets by category

	Total
	£000
Assets as per Statement of Financial Position	
NHS Trade and other receivables excluding non financial assets (at 31 March 2012)	**5,287**
Non-NHS Trade and other receivables excluding non financial assets (at 31 March 2012)	**1,499**
Cash and cash equivalents (at bank and in hand (at 31 Mar 2012)	**20,306**
Total at 31 March 2012	**27,092**
NHS Trade and other receivables excluding non financial assets (at 31 March 2011)*	5,426
Non-NHS Trade and other receivables excluding non financial assets (at 31 March 2011)*	1,519
Cash and cash equivalents (at bank and in hand (at 31 Mar 2011)	15,025
Total at 31 March 2011	21,970

* In the 2010/11 Accounts £8,373,000 of financial assets was all categorised as, Trade and Other Receivables, due to a reclassification of £1,428,000 from NHS Trade Receivables to Accrued Income, this has reduced to £6,945,000. Due to a change in guidance this has now been split between NHS and Non NHS.

All financial assets at 31 March 2012 and 31 March 2011 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	**6,194**
Obligations under Private Finance Initiative contracts	**84,335**
NHS Trade and other payables excluding non financial assets	**8,017**
Non-NHS Trade and other payables excluding non financial assets	**14,156**
Other financial liabilities	**-**
Total at 31 March 2012	**112,702**
Borrowings excluding Finance lease and PFI liabilities	6,756
Obligations under Private Finance Initiative contracts	85,543
NHS Trade and other payables excluding non financial assets*	5,402
Non-NHS Trade and other payables excluding non financial assets*	11,236
Other financial liabilities	-
Total at 31 March 2011	108,937

* In the 2010/11 Accounts £16,638,000 of financial Liabilities was all categorised as, Trade and Other Payables excluding non financial liabilities, due to a change in guidance this value has now been recategorised between NHS and Non NHS.

All financial liabilities at 31 March 2012 and 31 March 2011 were classed as other financial liabilities. The Trust had no liabilities held at fair value through income and expenditure.

30.3 Maturity of Financial liabilities

	31 Mar 2012	31 Mar 2011
	£000	£000
In one year or less	23,944	18,409
In more than one year but not more than two years	1,874	1,771
In more than two years but not more than five years	6,012	5,918
In more than five years	80,872	82,839
Total	112,702	108,937

30.4 Fair values of financial assets at 31 March 2012

	Book Value	Fair value
	£000	£000
Non current trade and other receivables excluding non financial assets	-	-
Other Investments	-	-
Other	-	-
Total	-	-

30.5 Fair values of financial liabilities at 31 March 2012

	Book Value	Fair value
	£000	£000
Non current trade and other payables excluding non financial liabilities	-	-
Provisions under contract	-	-
Loans	6,194	6,194
Other	-	-
Total	6,194	6,194

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.

30.6 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 to invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Board of Directors has approved a Treasury Management Policy which sets out the parameters for investing any surplus operating cash in short-term deposits. This includes the restriction of any such investment to permitted institutions with appropriate credit ratings; these ratings are in line with the guidance issued by Monitor 'Managing Operating Cash in NHS Foundation Trusts'. In addition the policy sets out the maximum limits for any such investments. The policy, and its implementation are reviewed by the Audit 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 2011/12 the Trust has financed its capital expenditure from internally generated funds. 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 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 2011/12 was £7,829,000 (£7,495,000 in 2010/11).

32 Limitation on Auditors Liability

There is no limit on our external Auditors liability.

33 Losses and special payments

33.1 Losses and special payments

There were 69 cases of losses and special payments totalling £173,000 during the period covered by these accounts (49 cases totalling £251,000 in 2010/11).

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.

33.2 Recovered Losses

The Trust has not received any compensation payments.

34 Accounting Standards that have been issued but have not yet been adopted.

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011/12. The application of the Standards as revised would not have a material impact on the accounts for 2011/12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation

IAS 12 - Income Taxes (amendment) - subject to consultation

IAS 19 Post-employment benefits (pensions) - subject to consultation

IAS 27 Separate Financial Statements - subject to consultation

IAS 28 Investments in Associates and Joint Ventures - subject to consultation

IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012/13

IFRS 9 Financial Instruments - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation

IFRS 11 Joint Arrangements - subject to consultation

IFRS 12 Disclosure of Interests in Other Entities - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IPSAS 32 - Service Concession Arrangement - subject to consultation

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

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