Calderdale and Huddersfield NHS

NHS Foundation Trust

Annual Report and Accounts 2012/13

Your Care
Our Concern

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

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts

2012/13

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Chairman's statement

They say a week is a long time in politics – well, they should sample a week in the NHS!

In July 2013, I will have notched up two years as Chairman of this Trust. That's 104 weeks of new and varied NHS challenges. Some we expect and plan for and some come out of the blue, such as the atrocious winter weather conditions. This year, on one memorable Friday in January, we had more than 700 attendances - double the usual number of attendances - at our A&E departments!

I can honestly say my role remains hugely satisfying, if increasingly challenging as the Trust prepares for one of the biggest reorganisations ever to affect the NHS. However, my job is made easier due to the fantastic teamwork at the Trust, be it the Executive Team, front line staff or the myriad of people behind the scenes who make the hospitals run efficiently.

New to our Board team this year has been our new Chief Executive Owen Williams. We welcomed him in May 2012 and nearly one year on I am convinced we appointed the right man for the job. He brings a fresh perspective to the Board and constructively challenges some of the traditional ways we have done things. I look forward to facing the challenges with him at the helm into the coming years. We also welcomed a new non-executive director, Mike Savage, replacing Bill Jones who retired after seven years on the Board, and has said goodbye to Jonathan Webb, who had acted up as Director of Service Development during the year and latterly held the post of Director of Commissioning and Partnerships.

For the NHS nationally, the most significant week of the year was undoubtedly the week of 6 February 2013 – the day of the publication of the second Francis report (into care at Mid Staffordshire NHS Foundation Trust) with its huge implications for all healthcare organisations across the country.

It's like a large mirror has been held up in front of the NHS, challenging us as to whether the circumstances at Mid Staffordshire could happen in our own organisations. Since its publication our Board, along with every board in the country, has taken a long, hard look at our working practices to make sure we are performing at the highest level for our patients in Calderdale and Huddersfield; that we really do Put Patients First. When we slip up, and we do occasionally, I want to be Chair of an organisation that acknowledges the failing, learns from it and makes sure it doesn't happen again, and whilst we do have our moments I am pleased to be able to say that for the vast majority of the time we are performing well.

That performance, 24/7, week in week out, is assisted hugely by our Membership Council. We said a farewell to its Deputy Chair Peter Naylor and colleague Jan Freer who worked so closely with our membership councillors to ensure we have a good, effective relationship geared up to improving patient care and experience. I would like to take this opportunity to thank them and also give a special vote of thanks to the membership councillors who have left us this year and also welcome to our newcomers.

Our membership councillors do a great job for us. They have maintained their important work commitment, taking part in reference groups and having their say when service changes are being considered. In the past year, their voluntary input - which has increased in the wake of the Health and Social Care Act – has included:

- Acting as "secret shoppers" to help us assess our radiology service from our patients' point of view;
- Accompanying staff on ward and clinic inspections to make sure the environment is as good as it can be for our patients;
- Helping to select the winners in each category in our 'Celebrating Success' staff awards; and
- Working with Trust staff to help modernise the public entrance and reception area at HRI.

Looking ahead to next year, there is no doubt the financial challenges will deepen as austerity measures impact across public sector services. We are working with our partners across the health and social care patch to ensure that, despite this, providing quality care continues to remain top of our agenda.

Really important in this context is the work going on across the health economy to redesign the way health and social care is provided in Calderdale and Kirklees. All of us, across seven different organisations, working together, to make sure that we are "fit for purpose" for the future.

Whatever changes we make, you can rest assured that patient safety, quality care and patient experience remain, unquestionably, our top priorities.

So, finally, with many more challenging NHS weeks to come I would like to offer my thanks to our 5,900 staff, our volunteers, and League of Friends supporters.

Without you going that extra mile for us, we wouldn't be the Trust we are.

Andrew Haigh
Chairman

"All of us, across seven different organisations, working together, to make sure that we are 'fit for purpose' for the future"

Chief Executive's statement

I was very proud to join Calderdale and Huddersfield NHS Foundation Trust in May 2012 at the start of what was going to be a challenging five years for the Trust, the NHS and the wider public sector in general.

Our annual plan runs up to 2015 and our aim is to continue to improve the care and experience our patients receive when they come to our Trust. For me and other colleagues across the Trust this is a 100% given and the many people that I have met have demonstrated a steely determination to meet the challenge of continuously better care for patients regardless of the changes in our external environment. The photo on this page is my pledge to that effect and I know from speaking to many people it is a pledge all our staff and partners would support.

I'm really pleased by the progress we have made this year. For example, we have delivered on a number of key performance areas such as dementia care and stroke services and we are working well with our partners to achieve quality, integrated care, particularly in the community - but we want to achieve more.

We are already working with our local partners in healthcare - the new Clinical Commissioning Groups, the local authorities, South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Mid Yorkshire Hospitals NHS Trust, Locala Community Partnerships and our pharmacy partners, the Co-operative, and this will very much continue to be the trend over the coming years.

As you would expect of any organisation that is serious about patient care, we have worked with patients, staff, partners and regulators to fully understand where we are now and what we need to do for the future. A feature of this work has been the growing importance of collaboration, both internally and externally, and an even greater emphasis on providing care in the right place, at the right time.

We will also continue to see more requirements from our commissioner colleagues for more services to be provided in the community and at home where possible, which is why, for example, the use of information technology will play an ever increasing role in what we do as a Trust. We are working hard with our partners to make these changes happen so that we can also enhance our hospital care for those people who really need to come to hospital.

'Your Care, Our Concern' is the Trust's motto, and remains central to all our work over the coming years. Our business is caring for our patients and, in times of huge change, that should never be forgotten.

So, looking ahead, there are four key themes which I expect will influence our future direction over the next few years and keep our Trust moving in the right direction.

They are:

- Keeping the base safe – we want to be recognised as a Trust that delivers safe, high quality patient care by our patients, their families and our staff.
- Internal reconfiguration and staff utilisation – as well as ensuring that our services are organised to the maximum effect for patients, we are looking to move our services to a seven-day working week so that our patients get their care when it is best for them. This is a huge cultural change for both staff and patients but we know it needs to happen.
- Integrating our services with primary and social care – working with them we need to redraw the local healthcare map to provide non-hospital care elsewhere in health centres, walk-in centres, and GP surgeries as well as in people's homes, if that is what our patients want.
- Strategic alliances – our Trust is working with like-minded organisations to ensure that, into the future, we can still deliver affordable care as locally as possible, where it is most appropriate to do so.

Of course, having a vision is all well and good – but it will just remain a statement of intent if we don't have measurable actions for which we are all accountable and we are working to a series of objectives to ensure we achieve our vision.

Central to our success will be the input and leadership from all our staff. One of our senior clinicians said that for us to be successful

Owen, right, with General Management Trainee Becky Gunn

"I'm really pleased by the progress we have made this year"

Chief Executive's statement continued

we all have to have the "courage to put our patients first". For me, that can only be achieved by having staff fully engaged with us. That process must start at the very beginning, when we are recruiting, through to ensuring that our long-serving colleagues feel valued and are supported in making the changes necessary to feel confident about their role in this new world.

What is important to our success is that staff feel they have the Trust's support to take decisions in the best interests of patient care, to be innovative and drive priorities and performance to achieve continuous improvements. It is also important that staff feel that they work in an environment where their ideas are taken on board and they are left in no doubt that the patient comes first.

The years ahead are going to be tough ones, yet we will continue to invest in improving the care we deliver for our patients despite a difficult financial climate. And by improving care for our patients we also hope to ensure that our services become more efficient, and by this we mean that where patients require healthcare their time spent with us is always productive for them.

I am convinced that driven by our patients, staff, membership councillors and partners we are well-placed to face the challenges ahead, keeping quality care at the forefront of all we do.

Owen Williams
Chief Executive

Directors' Report

The Calderdale and Huddersfield NHS Foundation Trust

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

Since those early days we have expanded beyond our hospital-based services and now provide a range of community services in Calderdale to meet the changing healthcare demands of our population. Five hundred new members of staff joined us from the former Calderdale Primary Care Trust last year to deliver this care.

As a Foundation Trust - a status gained in 2006 - we have had the freedoms to develop and invest in our services to make sure they are tailored to the best needs of our local patients. This status has enabled us to develop Acre Mill in Lindley, Huddersfield, with development partners Henry Boot and this former old mill is due to be transformed into a new outpatients centre providing 120,000 appointments a year by the summer of 2014.

We have also been able to move from the former Laura Mitchell Health Centre into the new Broad Street Plaza complex to continue to provide care in Halifax town centre. This was officially opened in February 2013.

The Birth Centre at Huddersfield Royal Infirmary celebrated five years of maternity care in March 2013 and also welcomed its 3,000th baby. The numbers of births there continues to grow year on year.

This year the Trust also welcomed a new chief executive, Owen Williams, who succeeded Diane Whittingham who left the Trust after 15 years at the helm.

The Trust has achieved all its national targets this year, despite the challenges it has faced both through the changing architecture of the NHS and through these times of austerity. Despite these challenging times, the Trust continues to invest in improvements to patient care and the patient environment to ensure patients receive the quality care they deserve.

What we do

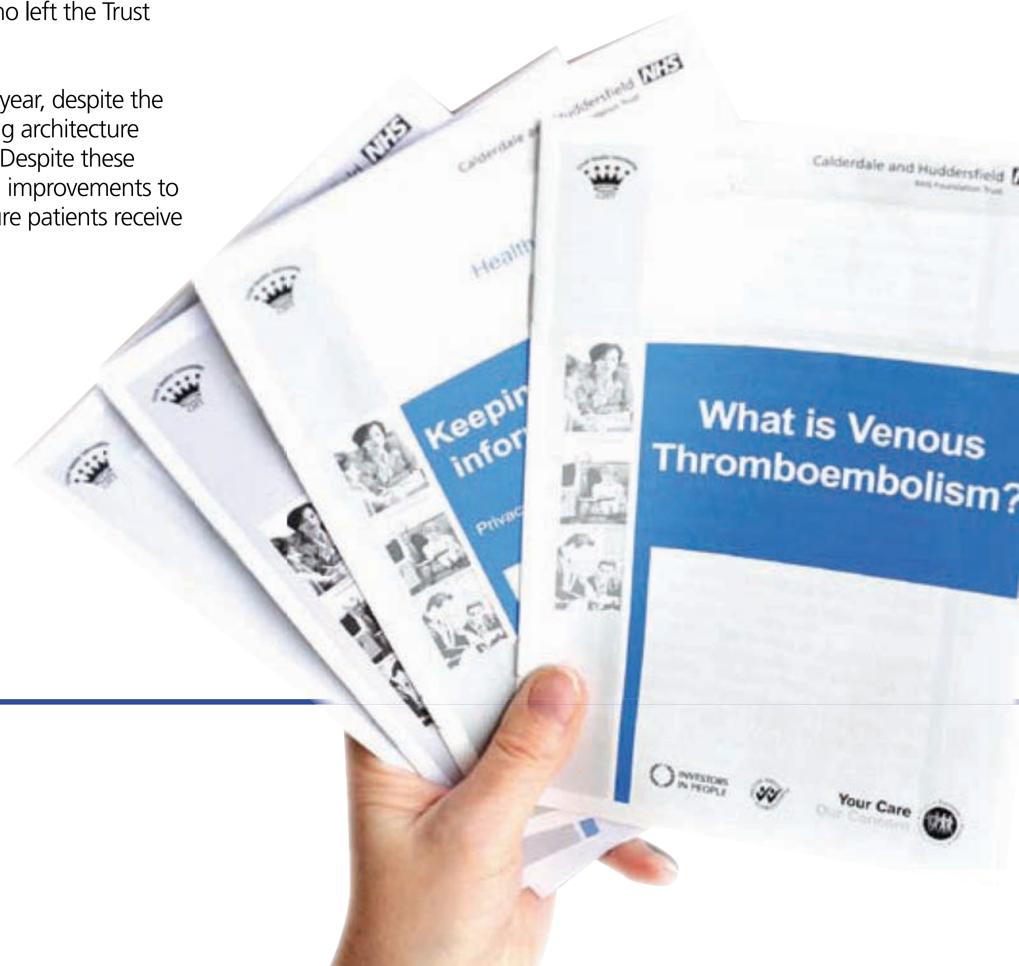
Our two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary, deliver an evolving and expanding range of healthcare services.

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 119,000 men, women and children were cared for as inpatients (stayed at least one night) or day cases and more than 414,000 people attended our outpatient clinics. Our A&E departments at both hospitals cared for more than 141,000 people.

From April 2012 to March 2013 some 185,000 adult service and 90,000 children service contacts were provided by our community teams.

The Trust also provides a full complement of Accident and Emergency, outpatient and direct access services. All main specialties are supported by a comprehensive range of clinical services in therapies, pharmacy, pathology, radiology, and cardio-respiratory.



The Vision for Calderdale and Huddersfield NHS Foundation Trust

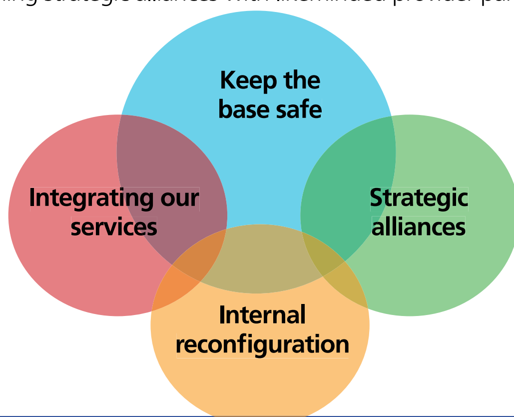
The design of the Trust's vision for the future has been built on a simple model called the three Rs, which relate to current **REALITY**, what we need to do in **RESPONSE**, and how we want things to be, **RESULT**.

During the latter part of 2012, the Trust undertook a significant review of its current **Reality**. This work involved patients, partners, membership councillors and other stakeholders. After developing this conversation, the Board of Directors, Membership Council and our Clinical and Managerial leads set out to describe the future **Result** for the Trust. This included a number of principles which, if the Trust responded appropriately, would produce the following signs of success:

- Patients and our staff being able to positively describe what 'Your Care, Our Concern' means to them, along with their own personal success stories that relate to our values of People, Patients, Partnerships and Pride.
- Living up to the desire for us to be clinically-led and treating our patients, staff and partners in a way that we would expect to be treated ourselves.
- Several examples of how we have collaborated in the interests of patients both within and outside Calderdale and Huddersfield NHS Foundation Trust.
- Improvements in real time patient information being at hand for us and our partners to provide the best seamless care.
- Ensuring our regulatory compliance by improving our access to care for patients and prioritising their safety.
- Meeting head on our financial circumstances and using this challenge as a driver for change and not solely as a constraint.

In developing our **Response** to achieve the Trust's desired **Result**, four broad strategic themes emerged which are described as follows:

- Keeping the base safe ensuring no drop in performance during turbulent times.
- Internal reconfigurations of services and staff utilisation.
- Integrating our services with primary care and social services.
- Establishing strategic alliances with likeminded provider partners.



" In my eyes standards of care and compassion in A&E at HRI set a benchmark that other health authorities can only dream of attaining"

DF, Honley, Letter to Examiner

Directors' Report

Response 1 - Keeping the base safe: Ensuring no drop in performance during turbulent times

The Trust operates in a regulatory and compliance framework which demands adherence to standards of patient safety and quality of care. There has also been a transformation in the expectations of patients and this is writ large in the Francis report which makes it clear that we must seek to continuously improve and move to a model of care which is patient-led.

In order to transform what we do it is imperative that the Trust meets its regulatory performance targets whether they are about patient safety and/or the quality of care. Success in compliance enables the Trust to look forward and develop/innovate patient care versus the alternative of becoming internally focused and forever chasing targets due to a lack of non-compliance.

As a part of keeping the base safe we will undertake a continuous improvement approach which will involve patients, doctors, nurses and porters et al in mapping out the current 'door to door' experience for patients. We will then co-develop the future state with the core aim of improving productive patient time and reducing/minimising unproductive patient time.

The post-Francis NHS demands new approaches and responses to the engagement and development of all our people, whether in clinical or non-clinical roles. The focus will be on care and compassion delivered by competent and appropriately qualified people who have the courage to put the patient first and are able to interpret the aim of 'Your Care, Our Concern' in a way that is real for them. The emerging NHS structural landscape demands new ways of working within a tighter fiscal environment where partnerships and collaboration thrive.

This will become the way we work and it is intended that this Response will not only have clear patient benefits but it will also help us to navigate the financial reality that will exist for at least the next decade.

Response 2 - Internal reconfigurations of services and staff utilisation

As a part of keeping the base safe and enabling the Trust to continually improve care there will inevitably be a need to change the way we work and reconfigure services. This is not just about where services are provided from as "bricks and mortar" don't provide care in themselves. This is about our people and how we change to meet the new demands placed upon us in a patient-led world. The following is an example of the responses that will be implemented in due course:

- Redesigning our workforce to deliver services 24 hours a day and 7 days a week.
- Redesigning our workforce to meet the changes in numbers of doctors and nurses in training.
- Training more nurses and allied health professionals in the extended scope roles to provide the new workforce.
- Providing more outreach services in the community, from all professional groups.
- Rolling out the pilot models designed to support patients with long term conditions to provide self-care.
- Building our electronic capacity to share records with other providers and access records remotely.
- Ensuring lean is the way we do things around here.

Internal reconfigurations of services and staff utilisation will also be an important part of the delivery of Cash Releasing Efficiency Savings (CRES). To allow safe and informed judgements to be made it is critical that the Trust uses the full range of management intelligences which are available. These include:

- Service Line Management and its development to patient level.
- The use of industry recognised benchmarking tools covering productivity, quality, safety and cost;
- Rapid deployment of Information Management and Technology (IM&T) solutions, e.g. e-rostering, electronic patient records;
- A clinically-led programme of innovation which will focus on new clinical practices and integration across primary and secondary care e.g. telehealth, more day case surgery;
- Strategic review of the estate to ensure appropriately sized footprint.

Response 3 - Integrating our services with primary care and social services

In recent years the Trust operated in an environment of comparative financial prosperity and investment in healthcare services. However, that era has concluded and the future will feature a need for much more organisational collaboration which is focused on meeting the needs of the patient versus the needs of individual organisations themselves.

As a result, we will continue to work as a part of the Strategic Review of Health and Social Care undertaken by the seven organisations that commission and deliver the majority of health and social care services in Calderdale and Huddersfield.

The unequivocal aim of the Strategic Review is to deliver a 'best in class' health and social care system which will have built capacity in our communities, integrates services and has industrialised the use of technology to transform the way we care for, and support, people. This transformational change will only be achieved with the active support of our stakeholders and local people.

To ensure this level of integration really exists, yet without undermining the divisional, clinical-led structures which are in place, a structured Programme Management Office (PMO) will be introduced. This office will ensure that plans are delivered on time and safely; and when investment is required to make change possible, a real return on that investment is delivered. In addition, the programme as outlined will be consistently communicated to staff and, wherever possible, these same staff empowered to make the necessary changes.

The financial programme will also support this work and this is exemplified by the capital investment programme. This includes a three year modernisation programme to provide 'best of breed' Electronic Patient Record (EPR) information sharing facilities across the local health community and the provision of robust infrastructure that will give access to high performing systems and accurate and timely information.

Response 4 - Establishing strategic alliances with likeminded provider partners

Whilst being cognisant of competition rules, the Trust plans to progress appropriate strategic alliances across South West Yorkshire Partnerships NHS Foundation Trust; Airedale NHS Foundation Trust; Mid Yorkshire Hospitals NHS Trust; and Locala Community Partnerships and other relevant providers.

The reason for this is two-fold, we are moving to an era of full on specialist commissioning which is evidenced in the most recent funding shift from local Clinical Commissioning Groups to Specialist Commissioners as a part of the national 'Everyone Counts: Planning for Patients 2013/14'. Whilst our Trust only has a comparatively small level of direct funding from specialist commissioning activity the reality is that certain commissioning decisions can have a domino effect on District General Hospital care such as we currently provide. In short the effect that a Specialist Commissioning focus on large regional centres can have is the reduction of the provision of local services for local people.

It is also the case that the reality of reducing resources for all public sector providers into the future makes collaboration for better patient safety and care a must.

Directors' Report

Stakeholder Relations

The changing landscape of commissioning for health services has required a year of transition.

The development of Clinical Commissioning Groups has been fully supported by the Trust with good working relationships emerging. The Trust has also worked closely with the Specialist Commissioning Group during the transfer of responsibilities to the NHS Commissioning Board (now NHS England) and participated in the development of Operational Delivery Networks and Strategic Clinical Networks.

Health and Wellbeing Boards released their strategies in the autumn of 2012 and asked key stakeholders, including our Trust, for their support and contribution towards the delivery of key priorities.

The Trust has actively supported the strategies for both Calderdale and Kirklees and is committed to working with the boards on areas such as reducing inequalities for children and older people, and boosting the local economy.

During the transition year, all organisations have maintained a focus upon areas of development across the organisations for improving patient discharge, reducing length of stay, stroke care and care of patients with dementia.

Our Trust is working closely with partners across West Yorkshire to ensure that all our services continue to be delivered safely and meet the needs of all of our population groups.

In 2012, the Trust embarked upon key strategic alliances with the Mid Yorkshire Hospitals NHS Trust, SWYPFT, Airedale NHS Foundation Trust, Locala Community Partnerships and other relevant providers. Such alliances will provide a framework for district general hospitals to work together to continue to deliver more specialist services locally within a new era of commissioning.

The Trust, with partners, has embarked upon a strategic clinical review focusing on better lives, improving health and working together for effective support. We want to improve the health, wellbeing and safety of all our communities by supporting people to be independent and to deliver the right care, in the right place at the right time. To do this, we need to change the way we provide health and social care services so that:

- You can easily access the right information and guidance so that you can make informed choices for you and your family;
- You are able to tell your story once and are then supported to make positive choices to manage yours and your family's health;
- Wherever possible quality, personalised care will be delivered close to your home to help you stay as safe, well and as healthy as possible, for as long as possible;
- Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities;
- High quality, safe, specialist care will be available when you and your family need them.

The programme has supported four care streams, each made up of clinicians, professionals and managers from all seven partner organisations, developing models of care for future services to meet this vision. These care streams have engaged with more than 2,000 members of the public to ensure the models that are developed are what the public want. This work will continue in 2013/14.

Our performance against local and national targets and quality indicators is subject to internal scrutiny and scrutiny by external organisations including our commissioners, the Care Quality Commission (CQC) and Monitor.

We continue to be registered with the Care Quality Commission without conditions. We have robust systems in place for monitoring progress against the targets set by Monitor – the external organisation which scrutinises the performance of all foundation trusts – and our commissioners.

We have robust structures and processes to enable review and reporting against our performance requirements and other contractual commitments. These processes enable us to demonstrate our productivity and efficiency to those who commission us, as well as identifying areas for further improvement.

Directors' Report

Patient Care

Delivering high quality patient care for our communities is the Trust's top priority. The Trust continues to develop its services for patients in an ever changing environment.

- Performance against national and local targets is reported monthly to the Board of Directors and the Trust works hard to deliver the requirements set out by the Care Quality Commission.

- The community services for adults and children in Calderdale, which became part of the Trust in 2012, are now firmly embedded within the organisation and provide a platform to build upon in the future. We are constantly working with local care providers to enhance pathways to ensure care is fully integrated for all of our patients.

- The newly-centralised stroke care teams at the Trust have been successful in gaining accreditation – amongst the first in West Yorkshire to do so. The stroke unit is comprised of an Acute Stroke Unit on ward 6d and rehabilitation wards at wards 7ABC at Calderdale Royal Hospital, along with a transient ischaemic attack (TIA) clinic which is run seven days a week.

  The accreditation was granted after a peer review group visited and looked at key aspects of the new, combined stroke services based at Calderdale Royal Hospital.

  The panel considered extensive evidence around the care pathway, training and listened to feedback from patients and their families about the care they had received. Gaining the accreditation so soon after centralising the service in 2012 represents a huge achievement and was down to the commitment, dedication and hard work of all staff in stroke services. This accreditation will allow the Trust to continue to provide exemplary stroke services for patients from the Huddersfield and Calderdale areas.

  The unit is now able to provide an extended 24-hour thrombolysis treatment where clot-busting drugs are administered as soon as possible after the onset of stroke symptoms to limit the long-term effects. Innovative telemedicine will enable nurses to liaise with stroke consultants to assess patients for the thrombolysis treatment 24 hours a day, 7 days a week.

- The Trust has signed up to the national 'Call to Action' for improving care of people with dementia in hospital. This involves a declaration that the Trust is committed to being a dementia-friendly hospital, and this will be monitored through the National Dementia Action Alliance.

  The Trust is working with community and local authority colleagues to ensure that people with dementia are only admitted to hospital when absolutely necessary and to improve our pathway to facilitate timely and safe discharge wherever possible back to the home environment.

  The Trust's dementia pathway includes screening for all patients aged 65 and over for any evidence of confusion when admitted to hospital. If confusion is identified the patient may be referred to mental health services for a more comprehensive assessment to identify the cause.

  The Butterfly Scheme is a care pathway that helps all staff to communicate with, and care for, people with dementia to meet their individual needs. Involvement of families and carers is central to this as staff need to be aware of the personal preferences and characteristics of each individual patient. A blue butterfly symbol is used for people with a confirmed diagnosis of dementia and once opted in to the scheme this will be activated on each hospital stay. Staff can now use a white butterfly for people who

Our accredited stroke team

Work began on the Acre Mill site

New pharmacy at HRI

are confused due to other causes. This type of confusion is often a temporary condition, therefore, the white butterfly is removed from the clinical record when the patient is discharged.

The Trust has more than 100 Vulnerable Adult Champions who have received extensive dementia training and work across wards and departments promoting excellent dementia care. They are supported by senior nurses, including mental health nurses and a dementia matron provides expert help for patients, relatives and carers.

Enhancing the environment for people with dementia is known to improve their experience by reducing risks such as falls, agitation, incontinence and infection. The use of colour, signage, calendar clocks, a social area with provision for dining, recreational activities including memorabilia and music, and a care pathway that puts the patients first promotes rest, nutrition, hydration and 'normality'.
In December 2012 our first dementia-friendly ward was opened and plans are in progress to refurbish and upgrade all wards and departments to these standards.

Future plans include extending the butterfly scheme to include intermediate care in Calderdale, developing more dementia-friendly environments in the hospital, the introduction of new nursing documentation which flags up patients at risk and signposts to the dementia pathway, and the development of a discharge pathway.

Providing a high standard of care for people with dementia in Calderdale and Huddersfield is a high priority. The dementia care pathway and patient outcomes are monitored strategically through Trust, local and regional networks and boards. This structure provides reassurance to our local community that we are committed to our declaration of providing dementia-friendly hospitals.

- Work has begun on the Acre Mill site, in Huddersfield, to provide a 21st century state of the art health centre. The Trust has been working closely with its partners, Henry Boot Developments Limited, to develop the site to provide new accommodation for outpatient services which are currently delivered in clinics across several locations. The plans include additional parking and ambulance drop off facilities.

- More than 400 men and women from our area have undergone percutaneous coronary intervention (PCI) or angioplasty and stenting since the service was introduced in 2011. Previously patients would have travelled to the Leeds General Infirmary for this procedure. However, following accreditation by the British Cardiovascular Intervention Society (BCIS) patients suffering from heart attacks and angina are now able to receive care locally with shorter waiting times and a reduced length of stay in hospital.

- July 2012 saw the opening of a new pharmacy at Huddersfield Royal Infirmary. The pharmacy in the main entrance is a collaboration between our Trust and The Co-operative Pharmacy, aimed at reducing waiting times for outpatients. The new service is a huge benefit for patients, staff and visitors and has been achieved at no additional cost.

- The Trust's team of breast cancer nurses won £1000 in the Best Patient Support Initiative category of the first Breast Cancer Care Nursing Network Awards. The Trust's team were the first in the country to research, create, test and pilot a new style of care for women with low to moderate risk cancers, who do not need chemotherapy.

  The patient education programme, supported by the Yorkshire Cancer Network, covers issues such as breast awareness after treatment, diet, exercise and coping strategies following diagnosis. The programme replaced the need for patients to attend routine hospital appointments and helps individuals to build up confidence for their future.

- The Trust's first consultant specialising in paediatric emergency medicine was appointed in July 2012. Dr Maya Naravi joined the team from Leeds Teaching Hospitals. The Trust cares for around 30,000 youngsters at both sites every year.

- New £160,000 state of the art equipment is now helping our teams care for more than 100 patients with lung cancer. The endobronchial ultrasound service (EBUS) uses an ultrasound probe on the tip of a thin telescope, inserted through the mouth, to look at the inside of the chest cavity and locate key abnormalities outside of the air tubes using ultrasound. Once located, a needle can then obtain a biopsy sample. Prior to the introduction of EBUS, patients travelled to the Leeds Teaching Hospitals for a more invasive procedure under general anaesthetic and required a three-day stay in hospital.

Directors' Report

The Trust is one of only four centres in the region to offer this service. The procedure is supported by the National Institute of Clinical Excellence (NICE) in their guidance for lung cancer produced in 2011.

- In November 2012 our Trust's new health centre in the Broad Street Plaza, Halifax, opened. Around 130 doctors, nurses and allied healthcare professionals from our Trust, formerly based at the Laura Mitchell Health Centre, are providing a range of clinics for adults and children in the new state-of-the-art building.

- Ward 19 at Huddersfield Royal Infirmary, an orthopaedic ward, has undergone a major rebuild and refurbishment this year, incorporating touch-base stations for nurses. The scheme is part of a five year £10 million rolling programme of improvements to wards and public areas at the Infirmary. The new Ward 19 benefits from energy saving windows and specialist equipment for orthopaedic patients, such as electronic hoists. The new touch-base stations aid visibility around the ward ensuring nurses are easily accessible to our patients and carers.

- A new phlebotomy facility has opened at Huddersfield Royal Infirmary. The new department is a specially-designed suite of six rooms aimed at maximising patients' privacy and dignity. The team of 24 phlebotomists perform more than 11,000 blood tests per month, testing for conditions such as diabetes, anaemia and infections.

- The first emergency aortic aneurysm stent procedure under local anaesthetic – usually only performed at major university hospitals - has been performed at Huddersfield Royal Infirmary. The three and a half hour procedure was performed following the transfer of a patient from Bradford Royal Infirmary to Huddersfield as the on call centre for West Yorkshire at the time of the emergency.

  During the procedure, consultant vascular surgeon Neeraj Bhasin performed the surgery in the groin under local anaesthetic to access the femoral arteries and consultant radiologist James Simpson inserted the stent designed to seal the ruptured aneurysm. The patient was well enough to be discharged just six days later as opposed to a lengthy stay in intensive care.

The opening of the health centre at Broad Street

Opening of the phlebotomy facility

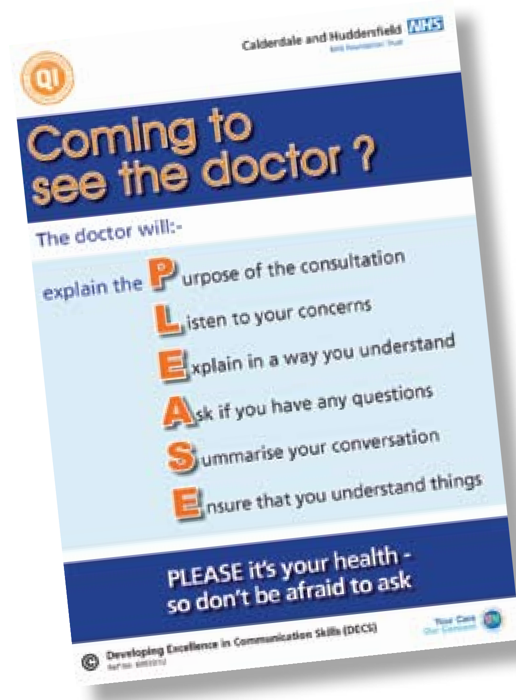
Patient information

The Trust recognises that information is a crucial part of the patient journey. Good patient information is important as it can give patients confidence, so their overall experience as a patient is improved, and allow people to make informed decisions – it gives people time to go away, read the information and think about the issues involved. This is important for achieving informed consent.

The Trust has a recognised patient information toolkit to ensure the information is written and printed to an agreed standard. Within the toolkit, it states that the material we produce will be clear, concise, relevant, accurate and in everyday language. It also aims to make information accessible to all taking into account language, literacy and removal of communication barriers for people with disabilities. The toolkit is reviewed annually and all written patient leaflets are reviewed bi-annually.

The Trust also works with the BIG WORD to ensure information is accurately translated into other languages and, where appropriate, interpreters are used to ensure patients understand information. Work has started to look at how patient information leaflets can be accessed from the Trust website. Where possible, the Trust has adopted a collaborative approach to improving patient/carer information.

Through our improvement work, such as the falls, dementia and pressure ulcer collaboratives, we have worked with patients and carers to improve the information we give out to ensure it is what users of our services consider important.



To ensure a safe discharge, the Trust is specifically examining the information that is given to patients regarding their medication on discharge from hospital.

The collaboratives have also worked with experts to ensure information provided to patients with dementia or a learning disability is easy to read and understand. Patients with a learning disability are provided with a VIP passport to highlight to professionals that they may require alternative methods of imparting information or communication. We intend to audit patient and carer experience regarding the information provided to them.

The Trust has a visual impairment work stream which is examining information in alternative formats to help visually-impaired people understand and comply with their medications.

The doctors' communication group has worked hard to ensure that both the standard of information and the way in which it is provided to patients is improved. The PLEASE poster has been designed to help ensure high quality consultations take place and this prompts colleagues to ensure both written and verbal information is given to patients. More importantly there is also a prompt to ensure patients understand the information they have received.

The information given to patients whilst they are in hospital is audited under the exemplar ward programme.

"I want to thank the staff in A&E and ward 10 who took admirable care of me making my stay as comfortable as possible"

BW Kirkheaton, Letter to Examiner

Directors' Report

Handling complaints

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

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

We also appreciate that these investigations can take a long time. We will, therefore, be reviewing our complaints management process to improve the way we handle complaints in the future.

Meeting the requirements of the Equality Act 2010

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
- Gender reassignment
- Sexual orientation
- Religion or belief
- Pregnancy and maternity
- Marriage and civil partnership (to a more limited extent)

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

The Trust 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.

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

STAFF

Sickness Absence

For 2012/13 the Trust's sickness absence rate was 4%. The Trust recognises that the health and wellbeing of its employees is a key determinant in safe and high quality services.

High rates of absenteeism are costly, from an economic point of view as well as the impact on the morale of the workforce and the potential loss of continuity of patient care. The Trust has a policy which supports regular attendance at work that enables managers to manage attendance fairly, with a focus on rehabilitation and return to work wherever possible.

Staff Engagement

The Trust recognises that employees play an important role in designing and delivering services which are of a high quality and which 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; and
- 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 "Saving Jobs Strategy" 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.

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

The Trust has been awarded an "Olympic Bronze" by the NHS Challenge 2012 for our on-going initiatives to keep our staff healthy. The Challenge aims to create a health and wellbeing legacy for the NHS as a result of the London Olympic Games. The award was presented to our Chief Executive Owen Williams at a ceremony in London by Sir David Nicholson, Chief Executive of the NHS.

The Trust has been recognised as an 'Investor in People' since 1999, one of only a few organisations in the country with more than 10 years of recognition. The Trust will continue to adopt the principles of the standard to support people management and development processes. The Investor in People Standard is a nationally-recognised business continuous improvement tool.

The Trust has in place a workforce health and wellbeing strategy which aims to influence improvements which impact positively on the health and wellbeing of all of our staff. The wellbeing of 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 the Trust's strategy is to identify workplace pressures in an attempt to avoid or manage work-related stress. This is supported by a series of staff engagement events to ensure staff have an opportunity to express their views and opinions about their work and working environment.

This complements the work the Trust does 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. Every year we take part in the 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 2012 a random sample of 850 members of staff were asked to fill in the survey and 505 responded (60%).

This year the Trust has one of the lowest scores, compared with other acute trusts, for work-related stress. The Trust has to constantly adapt to the changing needs of its patients and undertake service reviews to meet these needs. Trust staff are involved at all stages of this process.

Directors' Report

Where we are improving

The results of the staff survey in 2012 have shown that there is a high level of team working; Trust staff are receiving relevant training to support their job role; they have opportunities to contribute to improvements at work; and they believe that the Trust provides equal opportunities for career progression and promotion. The Trust has been working to reduce work-related stress levels and the score has improved from average to the lowest 20% of Trusts. The Trust will continue to support staff and managers in these areas as part of our health and wellbeing strategy.

Each division across the Trust is represented on the 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.

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

Summary of Performance in the National Staff Survey

	2011/12		**2012/13**		
Response rate	**Trust**	**National average for acute trusts**	**Trust**	**National average for acute trusts**	**Trust Position**
	60%	52%	60%	50%	No change
	2011/12		**2012/13**		
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Trust Position**
KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible		87%	81%	The Trust is performing above the national average
KF19. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	Because of changes to the format of the survey questions this year, comparisons with the 2011 score are not possible		18%	24%	The Trust is performing better than the national average
KF11. Percentage of staff suffering work-related stress in last 12 months	30%	29%	31%	37%	Increase of 1% - however the Trust is performing better than the national average
KF4. Effective team working	3.75	3.72	3.79	3.72	Increase of 0.04. The Trust continues to perform above the national average
	2011/12		**2012/13**		
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	**Trust Position**
KF7. Percentage of staff appraised in last 12 months	78%	81%	78%	84%	There has been no change to the Trust score - the Trust is performing below the national average
KF26. Percentage of staff having equality and diversity training in last 12 months	41%	48%	45%	55%	Increase of 4% - however the Trust is performing below the national average
KF8. Percentage of staff having well structured appraisals in last 12 months	34%	34%	32%	36%	Decrease of 2% - the Trust is performing below the national average
KF9. Support from immediate managers	3.69	3.61	3.57	3.61	Decrease of 0.12 - the Trust is performing below the national average

Directors' Report

Next Steps

The Trust will be developing a staff engagement strategy, informed by the external assessment conducted against the Investors in People Standard. The post-Francis NHS demands new approaches and responses to the engagement and development of all of our people, whether in clinical or non-clinical roles. The focus will be on care and compassion delivered by competent and appropriately qualified people who have the courage to put the patient first and are able to interpret the aim of 'Your Care, Our Concern' in a way that is real for them.

The engagement strategy will build on the four strategic themes which have been developed to ensure that the Trust is providing high quality, safe and dignified care, improving the quality of care and strengthening the links between patient care and patient experience. They are:

- Keeping the base safe;
- Internal reconfigurations and staff utilisation;
- Integrating our services with primary and social care; and
- Strategic alliances.

The Trust will be designing a comprehensive and integrated approach to the whole of the employment relationship based on the following elements:

- Delivering great leadership and management;
- Promoting a healthy and safe work environment;
- Enabling involvement in decision-making;
- Making sure every role counts;
- Supporting personal development and training.

In the spirit of positive staff engagement the Trust will look at the staff survey results in more detail to understand the actions needed to respond to the feedback.

The Trust will take every opportunity to reaffirm its commitment to 'Your Care Our Concern' with its underpinning values built around the 4Ps of Patients, People, Partnerships and Pride. One of the ways the Trust is doing this is to harness innovation from staff at every level in the organisation, through the introduction of a Staff Suggestion Scheme.

HEALTH AND SAFETY

By implementing good risk management strategies, current knowledge and best practice, the Trust ensures that it provides 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.

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 the Trust's services and facilities. The Trust's 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 and 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 continues to be delivered to staff which has been very well received by all.

Directors' Report

FINANCIAL STANDING AND OUTLOOK

Financial Performance Review

The national priorities for the NHS were set out in the NHS Operating Framework 2012/13. This was the second year of the quality and productivity challenge and the final year of the transition to the new commissioning and management system for the NHS. The framework described the requirement to respond to four inter-related challenges:

- the need to maintain the continued strong performance on finance and service quality;
- the need to address the difficult changes to service provision required to meet the QIPP challenge in the medium term;
- the need to complete the transition to the new delivery system set out in 'Liberating the NHS';
- the urgent need to ensure that elderly and vulnerable patients receive dignified and compassionate care.

At a local level, the Trust continued to work closely with its main commissioners and planned to deliver a financial surplus of £3.0million (m). The Trust has addressed this financial challenge and delivered a surplus of £3.8m, the operating part of which will be spent on improved facilities and equipment to benefit patient care.

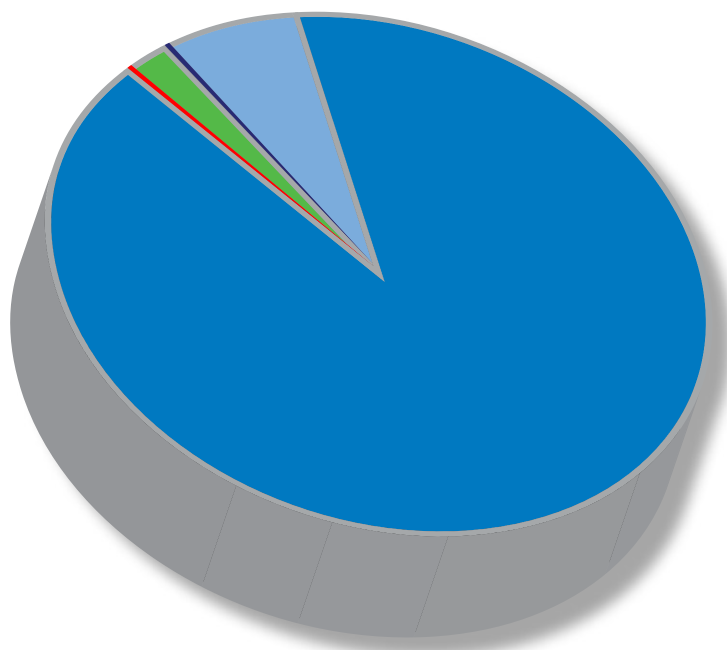
One of the key factors underpinning this financial performance was the delivery of a challenging cost improvement programme. During 2012/13 the Trust delivered savings of £14m and this was achieved through concerted management action driven through the Trust's clinical divisions and corporate strategic planning.

In addition, the Trust closed the year with a healthy cash balance of £33m that is to be utilised in supporting the trading and capital investments.

Income (excluding impairment reversals)
In 2012/13 the Trust received total operating income of £351m. The majority of the income £318m (90%) was for clinical services, with the remainder of £33m (10%) being delivered as non-clinical services such as education and commercial activities.

An analysis of income is shown below:

- **Clinical income £318m**
- **Research and development £1m**
- **Education and training £8m**
- **Charitable donations £1m**
- **Commercial and other £24m**



Nearly 91% of our clinical income came directly from our two main commissioners who purchased services from us on behalf of local patients and communities. These were:

- Calderdale PCT – 46% of clinical income during 2012/13;
- Kirklees PCT – 45% of clinical income during 2012/13.

In addition to these direct contracts, these organisations also commissioned certain specialist services (e.g. neonatal services) through regional consortium arrangements such as Yorkshire and The Humber Specialised Commissioning Group. Income from these regional specialised commissioning arrangements as well as "other clinical income" (such as overseas visitors and the NHS Injury Cost Recovery Scheme) accounted for the remaining 9% of income.

Within this, private patient income accounted for 0.17% of our total patient-related income. The statutory limitation on private patient income was repealed with effect from 1 October 2012 and can no longer effect our terms of authorisation as a Foundation Trust.

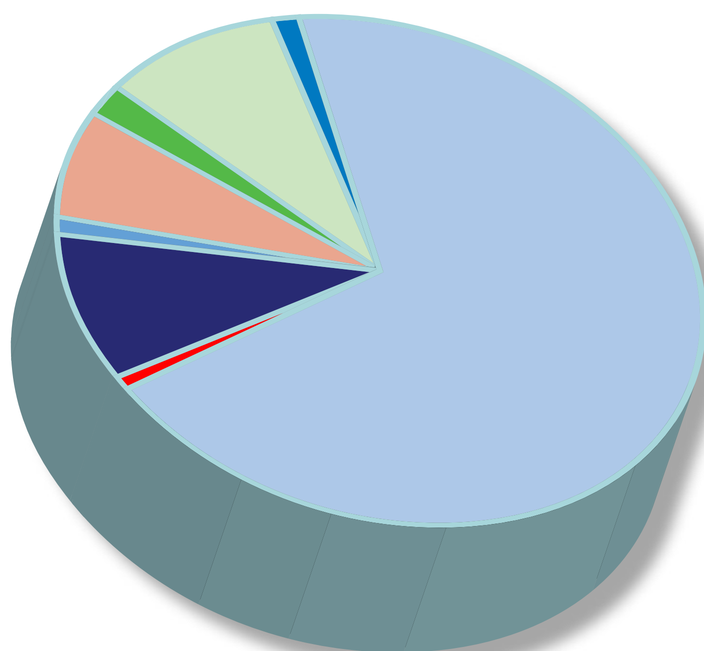
Non-clinical income is £33m with the majority of this income received to fund Education and Training, services provided to other organisations and commercial activities such as sales of manufactured pharmaceutical products and sales from the provision of catering facilities.

Within the year the Trust worked in partnership with its commissioners to identify transformational schemes that would lead to benefits across the whole health economy whilst improving the patient experience. The funding for these schemes was non-recurrent in nature, totalled £6m and focused on the following areas:

- Admission avoidance – investment in additional staffing within the Emergency Departments (ED) to support revised assessment processes.
- Readmission reduction – investment in additional staffing within the ED of a senior physician, Medical Assessment Unit (MAU) nurse and community matron support to reductions in readmissions.
- Length of stay reductions – investment has been made utilising lean methodology and developing a 'Plan for Every Patient'.
- Investment within medical equipment and IM&T to support patient experience/environment and infection control protocols.

Expenditure (excluding impairment charges)
Operating expenditure totalled £334m with the majority of expenditure being attributed to staff costs of 64% (£214m) and non-pay expenditure of 36% (£119m) that included items such as drugs, clinical supplies, Clinical Negligence Scheme (CNST) premiums and premises costs.

An analysis of operating expenditure is shown below:



- **Staff £214m**
- **Training and consultancy £3m**
- **Clinical supplies £29m**
- **General supplies £3m**
- **Drugs £23m**
- **CNST Premium £7m**
- **Premises £30m**
- **Equipment leases £4m**

Directors' Report

Breakdown of Total Expenditure

For every pound spent by the Trust in 2012/13 the breakdown of expenditure was as follows:

Nursing	23p
Medical	16p
Therapy and Scientific	10p
Healthcare Assistants and Support Staff	1p
Administrative and clerical staff	8p
Other non-clinical	5p
Total Staff	**62p**
Clinical Supplies	16p
Total Clinical Supplies	**16p**
General supplies	1p
Premises costs	9p
Other costs	4p
Total Support Services	**13p**
Depreciation	3p
CNST Premium	2p
PFI and Net Interest charges	4p
Total Other Costs	**9p**

Impairments

The reversal of impairment charges included in income in 2012/13 is £0.2m. 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 £6.3m.

Financial Risk Rating

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 a 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 2012/13.

Criteria	Metric	Planned score	Actual score	Planned rating	Actual rating
Underlying performance	Earnings before Interest, Tax, Depreciation and Amortisation as a % of income	8.2%	7.8%	3	3
Achievement of plan	Earnings before Interest, Tax, Depreciation and Amortisation as a % of plan	102.1%	99.8%	5	4
Financial efficiency Efficiency	Net Return on financing	1.7%	2.0%	3	4
	Income and Expenditure Surplus margin	1.1%	1.2%	3	3
Liquidity	Liquidity days	26.3	27.7	4	4
Overall Financial Risk Rating				**3**	**4**

Capital Expenditure

Capital expenditure in 2012/13 was £10.6m. Major schemes undertaken in 2012/13 included:

- **Medical equipment investment £1.9m** - Investment in new and replacement medical equipment including refurbishment of an X-ray room at Huddersfield Royal Infirmary (HRI) and replacement theatre tables.
- **Build works for a new CT scanner of £0.6m** - Investment in a new, leased CT scanner at HRI requiring enablement works.
- Ward refurbishment at HRI £1.9m - Orthopaedic ward refurbishment completed in December 2012 as part of the rolling ward refurbishment programme.
- **Information technology - infrastructure investment of £2.0m** - Significant investment in a new computer room supplying state of the art data storage facilities and additional investment to enhance the core infrastructure.
- **Information technology - clinical systems investment of £1.1m** - Investment within patient facing systems (PAS) and video conferencing technologies.
- **Operational and infrastructure schemes £2.4m** - Investment in Huddersfield Royal Infirmary to the main entrance, upgrades to fire compliance systems, window and lighting replacement schemes. Investment in Calderdale Royal Hospital as recognised in the Private Finance Initiative lifecycle programme.

Cash

The Trust closed the year with a healthy cash balance of £33m and has maintained a strong performance within the Better Payment Practice Code (BPPC). The BPPC requires the Trust to aim to pay valid invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The 2012/13 performance by month is shown below:

Financial Outlook and Going Concern

For 2013/14 the Trust is planning to deliver a £3m surplus for which the main income contracts have been agreed and signed with local commissioners. Within this plan is an assumption that the Trust will deliver further cost improvement savings of £16.4m.

In 2013/14 the Trust has established a capital investment programme of £14.9m, based on service and site strategy requirements and operational priorities in continually improving facilities and services provided by the Trust.

The cash position of the Trust is forecast to remain healthy and as such the Trust is not planning to utilise any of its authorised borrowing capability to achieve its 2013/14 capital programme.

The Trust recognises this period of austerity in public services is likely to continue until 2020, resulting in annual efficiency savings of circa 5% for the foreseeable future. In this same period we wish to invest heavily in the estate and IM&T. Therefore the challenge moving forward is to manage the balance between affordability and quality/standards of care, at a time of growing demand and increased public expectations. Therefore, as part of the wider health and social care system we anticipate the Cost Improvement Programme (CIP) challenge will remain at unprecedented levels for the foreseeable future. We aim to manage this through greater integration of services, reducing the variation of care across the system and significant productivity gains. Enhancing the collaborative working arrangements with commissioner and other provider organisations with appropriate risk sharing protocols will be critical.

Therefore, and 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.

Accounting Policies

The accounting policies in 2012/13 are in accordance with International Financial Reporting Standards (IFRS), with the annual accounts prepared in accordance with accounting standards and Monitor Annual Reporting Manual. The Trust's main accounting policies, including those for pensions and other retirement benefits, used to prepare the accounts are set out in the Trust's annual accounts detailed within page 123 onwards of this annual report.

Details of senior employees' remuneration can be found in the remuneration report as set out on page 50-54.

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

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.

Directors' Report

Fraud

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 has a dedicated section on counter fraud on the staff intranet with presentations being given to staff during the year about tackling fraud in the NHS and who to contact if they suspect fraud has been committed.

The Trust has a Fraud and Corruption Policy and Whistleblowing – Freedom of Speech Policy which incorporates counter fraud measures.

Our external auditors

The Trust's external auditors, the Audit Commission, resigned on 20 September 2012. The Trust completed a tender process and appointed KPMG as the external auditors who commenced on 20 September 2012.

The Audit Commission and KPMG have only performed audit work within the year and this is in line with Monitor's Audit Code for NHS Foundation Trusts.

Any non-audit work is reviewed by the Audit and Risk 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 independence of external auditors is properly maintained.

LOOKING TO THE FUTURE

The health and social care economy in Calderdale and Greater Huddersfield is working on a programme of transformation.

Both commissioning and provider services are working to address the significant challenges facing the health and social care sectors to ensure that people continue to receive high quality services, both now and in the future.

The 'Right Care, Right Time, Right Place' programme has seven partners. Joining the Calderdale and Huddersfield NHS Foundation Trust in this programme are: Calderdale Council; Calderdale Clinical Commissioning Group; Kirklees Council; Greater Huddersfield Clinical Commissioning Group; Locala Community Partnerships; and South West Yorkshire Partnership NHS Foundation Trust. The programme is being led by the two Clinical Commissioning Groups.

The aim of the programme is to improve the health, well-being and safety of local communities by supporting people to be independent and delivering the right care, in the right place at the right time. The intention is to do this by changing the way health and social care services are provided so that:

- People can easily access the right information and guidance so that they can make informed choices for them and their family;
- They are able to tell their story once and are then supported to make positive choices to manage their health;
- Wherever possible quality personalised care will be delivered close to home to help patients stay as safe, well and as healthy as possible, for as long as possible;
- Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities;
- High quality, safe, specialist care will be available when it is needed;
- Care will be delivered in partnership with people, enabling people to manage and control their condition, build resilience and independence to reduce their reliance on medical intervention where possible;
- Information will be shared where that is in the best interests of individuals and their families so that the relevant information is available to health and care professionals;
- Where possible care will be provided at home, or close to home with reduced reliance on hospital based services;
- The use of information and technology to enable integrated working, care at home and independence is maximised;
- There is open working and partnerships with shared ambitions to improve efficiency and the quality of care; and
- The available resources are used in the best possible way.

The programme is a journey. The journey has started but there is a long way to go.

The organisations involved will be working with patients, our communities and staff to take this programme forward over the next year.

Quality Report

The Quality Accounts are annual reports to the public from providers of NHS healthcare about the quality of the services they deliver. The primary purpose is to encourage boards and leaders of healthcare organisations to assess quality across all of the services they provide.

The Trust is committed to continually improving the quality of the services provided to its patients and the Quality Account is a report containing:

- How well the Trust performed against priorities set for 2012/13
- Trust priorities for the coming year (2013/14)
- How well the Trust performed compared to similar healthcare providers

The full quality account is available **from page 55** or via www.cht.nhs.uk and via NHS Choices. The following is a brief summary of content.

How we performed against the six priorities we set for 2012/13

Last year the Trust identified six quality improvement priorities for 2012/13.

The following summary shows how the Trust has performed against each of these priorities.

Improvement priority	Were we successful in 2012/13?
Reducing the number of pressure ulcers	Yes
Reducing the number(s) of healthcare associated infections - **Methicillin-resistant staphylococcus aureus (MRSA) bacteraemias**	Yes
Reducing hospital readmissions	Partially. We have seen an improvement but unfortunately we have not met our target.
Improving the care of patients with dementia	Yes
Improving doctors' communication with patients	Yes
Improving patient information on discharge	Yes

For reducing hospital readmissions the Trust's aim was partially met. Although a reduction of 40 patients returning to hospital following an acute admission was achieved this was below the target set. Some of the challenge faced was due to a 3% increase in the number of acute admissions.

Trust priorities for the coming year (2013/14).

This year the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our priorities for 2012/13;
- Looking at national priorities and things we have agreed with our commissioners (Clinical Commissioning Groups) as part of Commissioning for Quality and Innovation (CQUIN);
- Considering the priorities in 'Everyone Counts: Planning for Patients 2013/14' and the 'NHS Outcomes Framework 2013/14' - both documents shape our approach;
- Listening to what our regulators had identified as a priority;
- Taking into account reports and issues raised by organisations such as the Patients Association.

The long list was finalised into five priorities in conjunction with stakeholders, patients, staff, Foundation Trust members and the public.

The priorities chosen are:

- Healthcare associated infections
- Appropriate and safe discharge
- Care of patients with dementia
- Reducing healthcare acquired pressure ulcers
- Helping people to manage their long-term conditions

How well the Trust performed compared to similar healthcare providers

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

The following table summarises the Trust performance for these indicators compared to similar healthcare providers and, where they have not been met, gives a brief explanation.

Mandatory Indicator	Good performance against similar healthcare providers?	Explanation
Summary Hospital-Level Mortality Indicator (SHMI) • (i) the value and banding of the summary hospital-level mortality indicator (SHMI) for the Trust for the reporting period • (ii) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	 Yes Yes	
PROMS; patient reported outcome measures • groin hernia surgery • varicose vein surgery • hip replacement surgery • knee replacement surgery	 Yes No (0.5% below average for England) Yes Yes	 May be due to less pain and mobility problem prior to the procedure
Patients readmitted to a hospital within 28 days of being discharged • 0 to 14 Days • 15 days or over	 No No	 Due to reconfiguration of services
Responsiveness to the personal needs of patients	Yes	
Staff who would recommend the Trust to their family or friends.	Yes	
Patients admitted to hospital who were risk assessed for venous thromboembolism.	No	CQUIN target was met last year and compliance now increased but to date this is below the average for other Trusts.
Rate of C.difficile infection	Yes	
Patient safety incidents and the percentage that resulted in severe harm or death. • Rate of Patient Safety incidents per 100 Admissions • % of Above Patient Safety Incidents = Severe harm/Death	 No No	 Slightly below national average. In the Trust higher importance/severity is assigned to certain categories of incidents than in other Trusts

Sustainability and climate change

Following a successful reduction of carbon emissions in 2011/12 further initiatives have been implemented at the Trust to make further improvements in this area.

The improvements are:

- Replacing lighting with energy efficient LED lighting;
- Replacement windows;
- Installation of local energy controls;
- Installation of heat exchange units;
- Better use of transport services between the Trust's hospital sites;
- Replacement bedpan washers with more cost effective and efficient equipment;
- Improved segregation of general and food waste; and
- Recycling initiatives.

Equality and diversity report

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

- The elimination of unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010;
- Advancing equality of opportunity between people from different groups; and
- Fostering 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
- Gender reassignment
- Sexual orientation
- Religion or belief
- Pregnancy or maternity
- Marriage or civil partnership (to a more limited extent)

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:

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

Therefore, 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.

Staff engagement is supported by Staff 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 wellbeing 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. However, we acknowledge there is still more to do.

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.

An Equality, Engagement and Experience Board has been established, which was commissioned by and is accountable to the Trust's Quality Assurance Board.

The Equality, Engagement and Experience Board sits above specific workstreams related to service improvement for patients and staff within 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 communications office.

The Trust's employment record in the areas listed below can be accessed via the Trust website 'Equality and Human Rights' button. The areas are: 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 workstreams over the coming years.

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

Regulatory Ratings Report

	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

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

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

In August 2012 and January 2013 the Trust received improvement notices from the Care Quality Commission in relation to clinical documentation.

The Trust received a warning notice for failing to comply with regulation 20(1) (a) Records dated 8 April 2013. As the Trust was aware of this prior to the end of the financial year, it was declared to Monitor, which has resulted in the Amber-Red Governance rating for Quarter 4.

Significant work has been carried out to improve all clinical documentation within the Trust and we expect the Trust's Governance rating to improve as a result.

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 2012 to 31 March 2013 was as follows:

Board Member	Position	Tenure Review Date *
Andrew Haigh	Chairman	3 year office expires on 6.7.14
Alison Fisher	Non-Executive Director Vice Chair	Office expires on 30.9.13
Jane Hanson	Non-Executive Director and Audit Chair Senior Independent Non-Executive Director	3 years office expires on 30.9.14
Peter Roberts	Non-Executive Director	3 years office expires 22.9.14
David Anderson	Non-Executive Director	3 years office expires on 22.9.14
Jan Wilson	Non Executive Director	3 years office expires on 30.11.14
Mike Savage	Non Executive Director	3 years office expires on 31.10.15 (Appointed 1.11.12, resigned 31.3.13)
Bill Jones	Non Executive Director	Office ceased 31.10.12
Board Member	**Position**	**Appointment Date**
Owen Williams	Chief Executive	14.5.12
Helen Thomson	Director of Nursing/Deputy Chief Executive	1.4.93
Keith Griffiths	Director of Finance	25.7.11
David Wise	Medical Director	3.10.11
Lesley Hill	Director of Planning, Performance, Estates and Facilities	2.5.06
Johnathan Webb	Acting Director of Service Development	1.4.12 – 8.9.12
Julie Hull	Director of Personnel & Development	1.9.95

* 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."

Our Board Of Directors

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. The Trust's Non-Executive Directors were appointed because of their experience and specific skills and their strong links with the community. The Trust's 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 2012/13 the Board of Directors met on 12 occasions and attendance at these meetings is given in the table right:

NAME	ATTENDANCE AT BOARD OF DIRECTOR MEETINGS 1.4.12 – 31.3.13
NON EXECUTIVE DIRECTORS	
Andrew Haigh (Chairman)	10 / 12
David Anderson	09 / 12
Alison Fisher	09 / 12
Jane Hanson	08 / 12
Bill Jones	03 / 07 (Office ceased 31.10.12)
Peter Roberts	11 / 12
Mike Savage	05 / 05 (Appointed 1.11.12)
Jan Wilson	10 / 12
EXECUTIVE DIRECTORS	
Owen Williams (Chief Executive)	11 / 11 (Appointed 14.5.12)
Keith Griffiths	09 / 12
Lesley Hill	07 / 08 (Sabbatical 12.3.12 – 9.9.12)
Julie Hull	11 / 12
Helen Thomson	10 / 12
Jonathan Webb (Acting Director of Service Development 1.4.12 – 8.9.12)	09 / 11
David Wise	11 / 12

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

Andrew Haigh
Chairman

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

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

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

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Alison Fisher
Vice-Chair

Alison was appointed as a Non-Executive Director in December 2005. She is employed, part-time, by the West Yorkshire Probation Trust as Diversity and Development Manager and has a particular interest in issues of equality and diversity. She has worked for the Probation Service for 30 years and holds a Certificate of Qualification in Social Work, a Post Qualifying Award in Social Work and a Practice Teaching Award.

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. She is also a member of the Chartered Institute of Personnel and Development.

Alison was a representative parent on the General Teaching Council (England) for its first five years of operation and continued 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. She is currently a parent governor at a local High School and is a Wakefield Diocese lay representative on the General Synod of the Church of England. Alison lives in Huddersfield and has two daughters.

Jane Hanson
Non-Executive Director, Chair of Audit and Risk Committee and Senior Independent Non-Executive Director

Jane joined the Board in October 2008. A fellow of the Institute of Chartered Accountants, Jane qualified with KPMG, where she spent 12 years working in the financial sector practice where she latterly became Director responsible for the delivery of corporate governance, internal audit and risk management services in the North of England. With over 20 years' experience of working at Board level in large and complex organisations in financial services, Jane has also held Executive roles as Director of Audit and Risk and Governance Director at Aviva's Life business.

Jane is a Non-Executive Director and Chair of Board Risk Committee and Corporate Social Responsibility Committee at Direct Line Group plc; Non-Executive Director and Chair of the Audit and Risk Committee at The Reclaim Fund Ltd; and Independent Member of the Fairness Committee at Admin Re. Jane has her own financial sector consulting business, delivering audit, enterprise risk management and corporate governance services and is also a magistrate.

Formerly a professional musician, Jane is a music graduate from York University. She lives in Huddersfield with her family and as well as being a member of two orchestras, loves travelling and skiing.

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.

"From being admitted to my release I received immediate and top quality care and attention and nothing seemed too much for staff"

DA, Kirkburton, Letter to Examiner

Our Board Of Directors

Professor Peter Roberts
Non-Executive Director

Peter is Professor Emeritus of Sustainable Spatial Development in the Sustainability Research Institute at the University Of Leeds, Vice-Chair of the Northern Ireland Housing Executive and Group Chair of the First Ark Group – which includes a housing association and social enterprises. He lives in Kirkheaton and is married to Jo, a former nurse who worked at Kirkwood Hospice.

Nationally and internationally he is involved in a range of activities linked to regional and urban planning, regeneration, housing and health, economic development and environmental management. Peter has acted as an advisor to the House of Commons Childrens, Schools and Families Select Committee and to the Local Government Association.

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 supporting Liverpool FC.

Jan Wilson
Non-Executive Director

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

She has also worked in the West Midlands and Mersey 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 (SWYPFT).

Current positions include Lay Chair for junior doctor training with Yorkshire and the Humber Post Graduate Deanery, Non-Executive Director at Groundwork, Wakefield, Associate Hospital Manager at SWYPFT and Ambassador for Public Appointments with the Government Equalities Office. Jan has three sons and enjoys theatre, gardens and reading. She is a lifelong Manchester United supporter since school in Manchester.

Mike Savage
Non-Executive Director

Mike is a chartered accountant who has lived in Hebden Bridge for the last nine years and has 16 years' post-qualified experience working in large corporates and small medium-sized enterprises.

Mike has spent the last eight years operating as a finance director in Yorkshire and has 11 years' experience working within the regulatory environment of the Financial Services Authority. Mike also has significant audit experience through his time at Price Waterhouse Coopers and JP Morgan Chase.

Mike holds a BA (Hons) in Combined Social Sciences specialising in Economics, Business Management and Psychology from Durham University. He is married with a daughter and enjoys music, sport (in particular golf and skiing), with spare time frequently spent around the garden, or walking in the hills around Calderdale and Wharfedale.

Owen Williams
Chief Executive

Owen joined the Trust as its new Chief Executive in May 2012.

Before this he was Chief Executive of Calderdale Council providing managerial leadership across an organisation which serves a local population of 201,000 people and more than 7,500 businesses.

Prior to joining Calderdale Council he was Chief Executive of Rossendale Council and before that he worked in the commercial sector across Financial Services, Telecommunications and Marketing.

He has also worked with the Department of Health as part of its original Strategic Health Authority assurance process and was Joint Chair and Local Authority lead on the National Mental Health Strategy Board – No Health without Mental Health.

Owen, 44, was educated at the former Buttershaw Comprehensive School in Bradford and completed his MBA at the University of Huddersfield. Married with three children, he is a keen football fan and has resurrected his career as a basketball player – when his body and work permits.

Helen Thomson
Director of Nursing

Helen holds an MA in Leading Innovation and Change from York University and a BA (hons) in Management from Leeds University. She is also a registered nurse and midwife and holds the Advanced Diploma in Midwifery and the Midwife Teachers' Diploma.

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

In 1993, she took the post of Director of Operational Management then became Executive Director of Nursing and Clinical Development in April 1995. In April 2001, she has appointed Executive Director of Nursing for the newly-formed Calderdale and Huddersfield NHS Trust and has also held the post of Deputy Chief Executive since January 2006. She is a member of the University of Huddersfield Council and was appointed to the role of Deputy Lieutenant of West Yorkshire in September 2012.

Lesley Hill
Director of Planning, Performance, Estates and Facilities

Lesley has 22 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 sort out waiting list and patient access problems, and deliver modernised services.

In 2000 Lesley became the Director of Commissioning and Deputy Chief Executive for North Bradford Primary Care Trust. Lesley was Acting Chief Executive of North Bradford and Airedale Primary Care Trusts before her move to Calderdale and Huddersfield NHS Foundation Trust as Director of Service Development in 2006. In 2012 Lesley moved to her new role as Director of Planning. Performance, Estates and Facilities.

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

Keith Griffiths
Director of Finance

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

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

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

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

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

David Wise
Medical Director

David joined the Trust in 1994 as a Consultant Orthopaedic Surgeon. He became Divisional Director in 2001, Associate Medical Director in 2004 and was appointed Medical Director in October 2011.

The major agendas for the medical director role include refreshing the Trust's long-term clinical strategy, strengthening the quality and patient experience agendas with particular emphasis on understanding clinical outcomes, and strengthening the relationships between primary and secondary care.

His particular specialty is shoulder surgery and he works as a surgeon alongside his role as Medical Director. He is a former pupil of Huddersfield New College and attended Leicester Medical School with specialist training in the Yorkshire region.

David is married to a GP with two children, and away from medicine he is a keen sportsman enjoying golf, tennis and skiing.

Our Membership And Membership Council

The Trust's 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 Trust 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.

PUBLIC MEMBERS PER CONSTITUENCY (AS AT 31 MARCH 2013)	
Constituency	Number of Members
1	619
2	1998
3	1255
4	504
5	1233
6	745
7	1448
8	2192
STAFF MEMBERS PER CONSTITUENCY (AS AT 31 MARCH 2013)	
9	366
10	833
11	1237
12	1596
13	1873

Engagement Activities 2012/13

The role of the Membership Council is to ensure that the Trust takes account of 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 meets 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.

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 (DRG) meetings are held. Each DRG meeting discusses divisional business planning, divisional priorities and any service developments.

Each DRG is chaired by a Membership Councillor who, along with the other Chairs, meet the Trust Chairman at the quarterly Information Exchange. This "Chairman's Information Exchange" helps to keep both the Chairman and Membership Councillors up to date with key Trust priorities and issues.

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

When Membership Councillors' views are sought for a particular issue, an ad hoc working group is created. An example this year was the creation of a small working group of Membership Councillors, Executive Directors, and Non-Executive Directors to look at the implications of the recent Health and Social Care Act. Similarly, Membership Councillors are involved in plans to update the structure or fabric of Trust buildings. This year, Membership Councillors helped Trust colleagues with ideas to refurbish the layout and appearance of the hospital entrance at Huddersfield Royal Infirmary.

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.

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 a 'secret shopping' exercise to improve services in radiology.

Our Membership And Membership Council

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. Feedback is also gathered through 'reading panels' where members help to review and proof read patient information leaflets. This year, members also helped the Trust to focus its priorities by voting on a list of important patient safety and quality issues.

Two new electronic feedback opportunities were initiated this year. Since September 2012, members have been able to send their questions directly to the Trust Chief Executive or Chairman via a new electronic members' inbox. In October, the Trust conducted an electronic survey to seek views on the layout and content of its public website.

The Trust held its Membership Council/Board of Directors annual public meeting on 20 September 2012 at The Shay stadium in Halifax. This meeting was part of the annual Trust health fair and engagement event, 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 twice a 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 2012 to March 2013 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;
- Recruitment of new members at a Dementia Awareness Day, Kirklees College; and
- Recruitment at local sixth form college events, in collaboration with Practice Learning Facilitators, to help encourage local students to consider a career in the health service.

Two of the Trust's longest serving councillors retire in the summer of 2013 after many years' service on our Membership Council. Here, Bernard Pierce and Janette Roberts share their experiences and their views on the challenges facing the Trust in the future.

Janette is the lead Membership Councillor and her roles have included being a member of the inspection teams. She has also represented patients on the Gynaecology Forum. She believes it is important for our councillors to work with the organisation and, at the same time, be prepared to ask important questions so patients' views are heard.

On the future she says: "The Trust's strengths are that it is patient-focused, and works hard to provide care which is considered and planned and actively seeks to improve."

Janette Roberts

Bernard has been attending and chairing meetings and working with patients to get their concerns dealt with. He says he didn't realise the size of the Trust before getting involved, especially the scale of the back-up services such as the work in laboratories, laundry and patient records. He was also a judge in the staff awards 'Celebrating Success'.

On the future he says: "We are in difficult times and driven by things out of our control like austerity and complete change in the shape and structure of the NHS. It is important we are all vigilant in working to save the NHS and its founding principles."

Bernard Pierce

Our Membership Council

Our Membership Council has 28 places, of which 22 represent the public and staff and are elected by our members. The remaining six are appointed by partnership organisations. In 2012/13 these included: 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; and
- The preparation and review of the Trust's Membership Strategy, its policy for the composition of the Membership Council and of the Non-Executive Directors.

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

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

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

The Membership Council works closely with the Board of Directors. Directors routinely attend meetings of the Membership Council and representatives from the Membership Council attend Board of Director meetings. The Membership Council receives reports at each of its meetings from the Director of Finance and Director of Planning, Performance, Estates and Facilities on current issues of performance. In addition the Membership Council receives summary minutes of the monthly Board of Directors meeting together with the monthly Integrated Performance Report.

Elected Council Members

Summer elections were held in three public and four staff constituencies during 2012 and the results were announced at the Annual Members' Meeting in September 2012. By-elections were held in three public constituencies and one staff constituency in November 2012.

The elections were held under the independent scrutiny of the Electoral Reform Services.

There have been five formal meetings of the Membership Council during 2012/13 financial year and the attendance of the Membership Council members at these meetings is detailed on the next page.

"The level of care was incredible – they made us feel so relaxed, so welcome - so special"

New dad Dave Biddle on birth of IVF baby Poppy

Our Membership And Membership Council

NAME	CONSTITUENCY	ELECTED UNTIL ANNUAL MEMBERS' MEETING (Grey shading = current serving members)	ATTENDANCE AT FORMAL MEMBERSHIP COUNCIL MEETINGS 2012/13
PUBLIC			
Bernard Pierce	1	2013 (2nd term)	4 / 5
Martin Urmston	1	2015	1 / 3
Kimberley Cooper	1	2014	0 / 1
Linda Wild	2	2014 (2nd term)	4 / 5
Harjinder Singh Sandhu	2	2013	0 / 5
Peter Middleton	3	2014	5 / 5
Wendy Wood	3	2013	4 / 5
Christine Breare	4	2014 (2nd term)	5 / 5
Marlene Chambers	4	2015	3 / 3
Vera Parojcic	5	2013	1 / 1
Lisa Francis (nee Herron)	5	2013	3 / 5
Vic Siswick	5	2013	1 / 1
Peter Naylor	6	2012 (2nd term)	3 / 3
Sarah Slade	6	2014	0 / 1
Johanna Turner	6	2015	1 / 1
Liz Schofield	7	2014	4 / 5
Kate Wileman	7	2014	1 / 1
Jeannine Hind	7	2014	0 / 2
Jan Roberts	8	2012 (2nd term)	1 / 3
Janette Roberts (Deputy Chair 24.10.11 to present)	8	2013 (2nd term)	5 / 5
Andrew Sykes	8	2015	2 / 3
STAFF			
Mary Kiely	9	2014	3 / 5
Joanna Birch	10	2012	1 / 3
Avril Henson	10	2015	1 / 1
Eileen Hamer	11	2015	3 / 3
Sue Burton	11	2012	3 / 3
Liz Farnell	12	2012 (2nd term)	5 / 5
Chris Bentley	13	2012 (2nd term)	4 / 5
Julie Couldwell	13	2014	2 / 5
STAKEHOLDERS			
Sue Bernhauser	University of Huddersfield	2012 (2nd term)	1 / 2
John Playle	University of Huddersfield	2015	3 / 3
Bob Metcalfe	Calderdale Metropolitan Council	2014	3 / 5
Jan Giles	NHS Kirklees	2014	3 / 5
Sue Cannon	NHS Calderdale	2011 (2nd term)	1/5
Dawn Stephenson	South West Yorkshire Partnership NHS Foundation Trust	2013	4 / 5

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 and Risk Committee

The Trust has an Audit and Risk Committee which met nine times during 2012/13. The primary role of the Audit and Risk 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 and Risk Committee has approved Terms of Reference which are available on request and are regularly reviewed.

The Audit and Risk 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 2012/13 the Board of Directors extended the invitation to Andrew Sykes, Publicly Elected Membership Councillor, to assist the Audit and Risk Committee in discharging its duties and take on the role of Observer on the Audit and Risk Committee.

The Non-Executive Director (and Membership Council Observer) membership and attendance of the Audit and Risk Committee for the period 1.4.12 to 31.3.13 was:

NAME	ATTENDANCE AT AUDIT AND RISK COMMITTEE MEETINGS 1.4.11 – 31.3.12
Jane Hanson (Chair from 1.2.10)	9 / 9
Bill Jones (tenure ceased 31.10.12)	4 / 6
Jan Wilson	7 / 9
Alison Fisher	6 / 9
Mike Savage (appointed 1.11.12)	3 / 3
Andrew Sykes (appointed December 2012 as Membership Council Observer on Audit and Risk Committee)	2 / 3

Quality Assurance Board

The Quality Assurance Board (QAB) is a sub-committee of the Board of Directors and has no executive powers other than those specifically delegated.

The QAB is chaired by the Director of Nursing and has two Non-Executive Directors of the Board. Membership includes other directors and other senior staff from the Trust.

The purpose of the QAB is to monitor, review and report on the quality of services provided by the Trust. This will include review of:

- Governance, risk management and internal control systems, to ensure that the Trust's services deliver safe, high quality, patient centred care.
- Outcomes, through feedback and escalation from the Clinical Outcomes Board, to ensure that the Trust continues to meet the legal requirements for ongoing registration with the Care Quality Commission (CQC).
- Performance against quality indicators within the contract with the commissioners.

During 2012/13 the QAB met on seven occasions.

Charitable Funds Committee

The Trust, which is directed by the Board, acts as the Corporate Trustee of the Calderdale and Huddersfield NHS Foundation Trust Charitable Funds. The Foundation Trust's charitable funds are operated for the benefit of staff and patients in accordance with the objects of the charity. The funds are used for the purchase of equipment and provision of amenities for both patients and staff in accordance with the objects of the charity. The Charity received generous donations throughout the year, from many parts of the community, for which it is very grateful.

During the year the Charitable Funds purchased a large number of items of equipment and enhancements to fixtures and fittings for the wards and departments within the Foundation Trust. A full set of accounts relating to the charitable funds is available from the Director of Finance.

The Charitable Funds Committee is a formal sub-committee of the Board. It was established to provide assurance to the Corporate Trustee and to oversee the investment and utilisation of charitable funds in line with the objectives of the Charity. It is made up of representatives from the Trust's Board of Directors and the Membership Council.

Nominations Committee

Non-Executive Directors

The Nominations Committee for Non-Executive Director appointments is a sub-committee of the full Foundation Trust Membership Council. The standing membership of the sub-committee is:

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

The quorum necessary for the transaction of business is four members of the sub-committee, one of whom must be the Chair (or Vice Chair/Acting Chair).

Attendees for advice and committee support:

- Director of Personnel and Development
- Board Secretary

The sub-committee met on three occasions (31 May 2012, 5 September 2012 and 17 September 2012) to discuss and appoint to Non-Executive appointments arising in-year. The sub-committee made the following decisions:

- The offer of a further 12 month term of office to Mrs Alison Fisher, Non-Executive Director to take effect from 1 October 2012 until 30 September 2013.
- The appointment of one Non-Executive Director, Mr Mike Savage – for 3 years from 1 November 2012 until 31 October 2015. Mr Savage resigned on 1.4.13.

In accordance with best practice, the Nominations Sub-Committee commissioned the services of an external recruitment consultancy (Odgers Berndtson) to assist with the recruitment of the Non-Executive Director.

Name	Attendance at 31.5.12 Nominations Sub-Committee	Attendance at 5.9.12 Nominations Sub-Committee	Attendance at 17.9.12 Nominations Sub-Committee
Mr Andrew Haigh (Chairman)	✘	✔	✔
Mrs Chris Breare	✔	✔	✔
Mrs Linda Wild	✘	✘	✘
Mrs Sue Bernhauser	✔	✘	✘
Mrs Jan Roberts	✔	✔	✔
Mr Owen Williams	✔	✔	✔
Mr Keith Griffiths (co-opted as Finance Assessor)		✔	✔

Executive Directors

The Nominations Committee for Executive Directors is the Board of Directors and in 2012/13 the Board agreed at its meeting on the 22 November 2012 to establish the following Director portfolios:

- Director of Planning, Performance, Estates and Facilities (Executive)
- Director of Commissioning and Partnerships (Attendee)

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 NHS Foundation Trust (the annual IDS NHS Boardroom Pay Report), together with Foundation Trust Network information, Department of Health guidance and, in accordance with the Terms of Reference for the committees, advice from independent advisors. The way in which the committees operate is subject to audit scrutiny.

Remuneration of Non-Executive Directors

The Remuneration and Terms of Service Sub-Committee of the Membership Council sets the remuneration and terms of service for the Non-Executive Directors of the Foundation Trust.

In 2012/13 the sub-committee met on the 27 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 2012/13 financial year the members were as follows:

- Mrs Jan Giles, nominated stakeholder member – Chair (for this meeting only)
- Mrs Eileen Hamer, staff elected member
- Mrs Janette Roberts, public elected member
- Miss Lisa Francis, public elected member
- Mrs Wendy Wood, public elected member
- Mr Bernard Pierce, public elected member

Unfortunately owing to unforeseen circumstances the sub-committee was not quorate on the occasion that it met. However, the three members present agreed that the business of the meeting could be conducted and subsequently shared with the full membership for ratification. The sub-committee agreed this approach on the basis that there were no recommendations of substance regarding the remuneration of the Non-Executive Directors. The recommendation was to adhere to the NHS pay freeze provisions for the 2012/13 financial year and therefore no uplift in remuneration was made to Non-Executive roles. 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.

Name	Attendance at 27.3.13 Remuneration and Terms of Service Sub-Committee for Non-Executive Directors
Mrs Jan Giles (Chair)	✔
Mrs Eileen Hamer	✔
Mrs Janette Roberts	✘
Miss Lisa Francis	✘
Mrs Wendy Wood	✔
Mr Bernard Pierce	✘

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 2012/13 financial year the sub-committee met on 21 March 2013.

The business of the sub-committee was conducted in accordance with its Terms of Reference. The members of the sub-committee were as follows:

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

- Mr Owen Williams, Chief Executive – in attendance

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

The Remuneration Committee, in setting the pay of the Executive Directors, based its decisions on Department of Health guidance, Foundation Trust Network pay data, and IDS NHS Boardroom Pay Reports.

Name	Attendance at the Remuneration Committee 21.3.13
Mr Andrew Haigh	✔
Dr David Anderson	✔
Mr Mike Savage	✔
Professor Peter Roberts	✔
Mrs Alison Fisher	✘
Mrs Jan Wilson	✘

Additional Information

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.

Salary and Pension entitlements of senior managers

A) 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.

Name and Title	2012/13				2011/12			
	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)	45 - 50				35 - 40			
S Sharma ~ Chair (Note A)	0				0 - 5			
A Fisher ~ Non-Executive Director	10 - 15				10 - 15			
J Hanson~ Non-Executive Director (Note B)	20 - 25				15 - 20			
W Jones ~ Non-Executive Director (Note C)	5 - 10				10 - 15			
D Anderson ~ Non-Executive Director (Note D)	10 - 15				5 - 10			
Prof P Roberts ~ Non-Executive Director (Note D)	10 - 15				5 - 10			
J Wilson ~ Non-Executive Director	10 - 15				0 - 5			
M Savage ~ Non-Executive Director (Note E)	0 - 5							
M Brearley ~ Director of Finance (Note F)	0				10 - 15			
J Webb ~ Acting Director of Finance (Note F)	0				30 - 35			
J Webb ~ Acting Director of Service Development (Note G)	65 - 70							
K Griffiths ~ Director of Finance	145 - 150				100 - 105			
L Hill ~ Director of Planning, Performance, Estates & Facilities (Note H)	100 - 105				130 - 135			
J Hull ~ Director of Personnel & Development	120 - 125				120 - 125			
Y A Oade ~ Medical Director (Note I)	0				50-55			
D Wise ~ Medical Director (Note I)	130-135				50-55			
H Thomson ~ Director of Nursing (Note J)	130-135				130-135			
D Whittingham ~ Chief Executive (Note K)	0				190-195			
O Williams ~ Chief Executive (Note L)	160-165							
Additional disclosure								
Band of the highest paid Director's total remuneration	160-165				190-195			
Median Total (£'000)	27,625				27,424			
Remuneration ratio	6				7			

A – A Haigh appointed as Chair 07.07.2011 following the death of S Sharma April 2011
B – J Hanson is the Chair of the Audit and Risk Committee
C – W Jones resigned 11.11.12
D – D Anderson and Prof P Roberts were appointed 23.09.11
E – M Savage appointed 01.11.12 and resigned 31.03.13
F – J Webb acted up as Director of Finance from 01.05.11 to 25.07.11 between M Brearley leaving the post of Director of Finance and K Griffiths starting.
G – J Webb acted up as Director of Service Development from April to September 2012.
H – L Hill salary reduced due to leave within 2012/13
I – Y Oade in post until 02.10.11 replaced by D Wise on 03.10.11. The salary details disclosed for D Wise are apportioned on an estimate of time spent on management rather than clinical duties.
J – H Thomson covered the Chief Executive post until O Williams started on 14.05.12. From October 2012 to March 2013 the salary details for H Thomson were shared between Calderdale and Huddersfield NHS Foundation Trust and Mid Yorkshire Hospitals NHS Trust based on the time spent on duties.
K – D Whittingham resigned in April 2011
L – O Williams appointed as Chief Executive on 14.05.12

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 2012/13 was £160k - £165k. This was 6 times the median remuneration of the workforce, which was £27,625.

Reporting bodies are required to disclose expenses paid to Trust's Governors and Directors in the Financial year 2012/13 £9.5k was paid in expenses.

"I'd arrived at A&E at 11.20 pm and was back in the car for 11.40 pm. That must be a record. So well done to the NHS"

AH, in Examiner article

B) Pension Benefits

Name and title	Real increase in pension at age 60	Real Increase/ (Decrease) in Lump sum at age 60 related to real increase in pension	Total accrued pension at age 60 at 31 March 2013	Lump sum at age 60 related to accrued pension at 31 March 2013	Cash Equivalent Transfer Value at 31 March 2013	Cash Equivalent Transfer Value at 1 April 2012	Real Increase/ (Decrease) in Cash Equivalent Transfer Value
	(bands of £2,500) £000	(bands of £2,500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000
K Griffiths ~ Director of Finance	2.5 - 5.0	10.0 - 12.5	40 - 45	130 - 135	727	562	146
L Hill ~ Director of Planning, Performance, Estates and Facilities	(2.5) - 0	(5) - (2.5)	35 - 40	115 - 120	658	624	2
J Hull ~ Director of Personnel and Development	0.0 - 2.5	0 - 2.5	40 - 45	130 - 135	795	721	36
J Webb ~ Director of Service Deveolpment (Acting)	2.5 - 5.0	7.5 - 10.0	10 - 15	40 - 45	200	147	45
D Wise ~ Medical Director (Note I)	2.5 - 5.0	12.5 - 15.0	80 - 85	245 - 250	1,621	1,408	139
H Thomson ~ Director of Nursing	7.5 - 10	22.5 - 25.0	70 - 75	210 - 215	1,421	1,174	186
O Williams ~ Chief Executive (Note J)	55.0 - 57.5	0	55 - 60	0	577	0	577

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

I, The pension benefit details disclosed for D Wise are apportioned on an estimate of time spent on management rather than clinical duties.
J, O Williams started 14.05.12 no previous NHS service.

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

Real Increase/ (Decrease) in CETV
As of 22nd July 2010 all CETV factors are based on Consumer Price Index (CPI).

Mr Owen Williams
Chief Executive
May 2013

QUALITY ACCOUNT 2012/13

Chief Executive's Statement

Welcome to the 2012/13 Calderdale and Huddersfield NHS Foundation Trust Quality Account.

This report allows us the opportunity to tell you about the quality of services we deliver to our patients. It focuses on key priorities identified for further work in the past year and those areas that we have identified as priorities for the coming year.

Please be assured that much more work on service quality and patient experience continues within the Trust and this is just a snapshot of the work being undertaken.

Quality, simply defined, is how good or bad something is. For me, quality is about getting it right first time so that our patients are treated in the right place at the right time and by the right people.

Our staff work hard and are very committed to continuously improving and we are working hard to ensure that our patients get the quality of service that they deserve whenever, and wherever, they access our services.

The recent report by Sir Robert Francis QC on the failings at Mid Staffordshire Hospitals NHS Foundation Trust has, quite rightly, put a renewed focus on the quality of NHS services across the country. Our Trust is no exception and we are working to incorporate Francis' recommendations into our daily work.

We know that in our Trust there are good examples of exceptional quality and other areas where the quality is not yet where we would like it to be. Our Board of Directors is focused on raising quality across the Trust and that includes the quality of its own governance to which we have commissioned an independent review.

Quality will continue to be a top priority into the future. We want to have pride in the services we offer and we want our patients to be proud and happy to receive them.

The following pages will hopefully give you an insight into the vast array of quality improvement work going on within the Trust and the importance we place on this work.

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

Owen Williams
Chief Executive

"I really enjoyed my day. It was an amazing experience to see how a big organisation works"

A-level student Maariya Mahmood who shadowed our CEO for a day

The Vision for Calderdale and Huddersfield NHS Foundation Trust

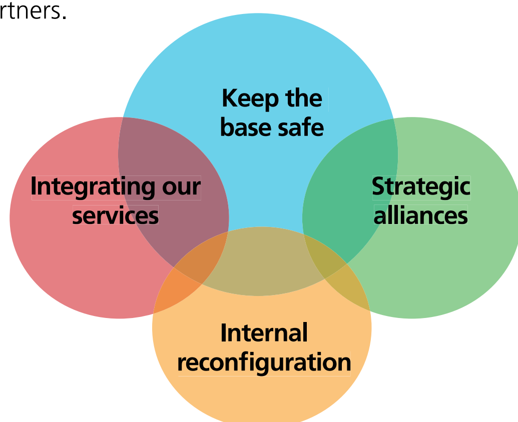
The design of the Trust's vision for the future has been built on a simple model called the three Rs, which relate to current **REALITY**, what we need to do in **RESPONSE**, and how we want things to be, **RESULT**.

During the latter part of 2012, the Trust undertook a significant review of its current **Reality**. This work involved patients, partners, membership councillors and other stakeholders. After developing this conversation, the Trust Board, Membership Council and our Clinical and Managerial leads set out to describe the future **Result** for the Trust. This included a number of principles which, if the Trust responded appropriately, would produce the following signs of success:

- Patients and our staff being able to positively describe what 'Your Care, Our Concern' means to them, along with their own personal success stories that relate to our values of People, Patients, Partnerships and Pride.
- Living up to the desire for us to be clinically-led and treating our patients, staff and partners in a way that we would expect to be treated ourselves.
- Several examples of how we have collaborated in the interests of patients both within and outside Calderdale and Huddersfield NHS Foundation Trust.
- Improvements in real time patient information being at hand for us and our partners to provide the best seamless care.
- Ensuring our regulatory compliance by improving our access to care for patients and prioritising their safety.
- Meeting head on our financial circumstances and using this challenge as a driver for change and not solely as a constraint.

In developing our **Response** to achieve the Trust's desired **Result**, four broad strategic themes emerged which are described as follows:

- Keeping the base safe ensuring no drop in performance during turbulent times.
- Internal reconfigurations of services and staff utilisation.
- Integrating our services with primary care and social services.
- Establishing strategic alliances with likeminded provider partners.



Response 1 - Keeping the base safe: Ensuring no drop in performance during turbulent times.
The Trust operates in a regulatory and compliance framework which demands adherence to standards of patient safety and quality of care. There has also been a transformation in the expectations of patients and this is writ large in the Francis report which makes it clear that we must seek to continuously improve and move to a model of care which is patient-led.

In order to transform what we do it is imperative that the Trust meets its regulatory performance targets whether they are about patient safety and/or the quality of care. Success in compliance enables the Trust to look forward and develop/innovate patient care versus the alternative of becoming internally focused and forever chasing targets due to a lack of non-compliance.

As a part of keeping the base safe we will undertake a continuous improvement approach which will involve patients, doctors, nurses and porters et al in mapping out the current 'door to door' experience for patients. We will then co-develop the future state with the core aim of improving productive patient time and reducing/minimising unproductive patient time.

The post-Francis NHS demands new approaches and responses to the engagement and development of all our people, whether in clinical or non-clinical roles. The focus will be on care and compassion delivered by competent and appropriately qualified people who have the courage to put the patient first and are able to interpret the aim of 'Your Care, Our Concern' in a way that is real for them. The emerging NHS structural landscape demands new ways of working within a tighter fiscal environment where partnerships and collaboration thrive.

This will become the way we work and it is intended that this **Response** will not only have clear patient benefits but it will also help us to navigate the financial reality that will exist for at least the next decade.

Response 2 - Internal reconfigurations of services and staff utilisation
As a part of keeping the base safe and enabling the Trust to continually improve care there will inevitably be a need to change the way we work and reconfigure services. This is not just about where services are provided from as "bricks and mortar" don't provide care in themselves. This is about our people and how we change to meet the new demands placed upon us in a patient-led world. The following is an example of the responses that will be implemented in due course:

- Redesigning our workforce to deliver services 24 hours a day and 7 days a week.
- Redesigning our workforce to meet the changes in numbers of doctors and nurses in training.

- Training more nurses and allied health professionals in the extended scope roles to provide the new workforce.
- Providing more outreach services in the community, from all professional groups.
- Rolling out the pilot models designed to support patients with long term conditions to provide self-care.
- Building our electronic capacity to share records with other providers and access records remotely.
- Ensuring lean is the way we do things around here.

Internal reconfigurations of services and staff utilisation will also be an important part of the delivery of Cash Releasing Efficiency Savings (CRES). To allow safe and informed judgements to be made it is critical that the Trust uses the full range of management intelligences which are available. These include:

- Service Line Management and its development to patient level.
- The use of industry recognised benchmarking tools covering productivity, quality, safety and cost;
- Rapid deployment of Information Management and Technology (IM&T) solutions, e.g. e-rostering, electronic patient records;
- A clinically-led programme of innovation which will focus on new clinical practices and integration across primary and secondary care e.g. telehealth, more day case surgery;
- Strategic review of the estate to ensure appropriately sized footprint.

Response 3 - Integrating our services with primary care and social services

In recent years the Trust operated in an environment of comparative financial prosperity and investment in healthcare services. However, that era has concluded and the future will feature a need for much more organisational collaboration which is focused on meeting the needs of the patient versus the needs of individual organisations themselves.

As a result, we will continue to work as a part of the Strategic Review of Health and Social Care undertaken by the seven organisations that commission and deliver the majority of health and social care services in Calderdale and Huddersfield.

The unequivocal aim of the Strategic Review is to deliver a 'best in class' health and social care system which will have built capacity in our communities, integrates services and has industrialised the use of technology to transform the way we care for, and support people. This transformational change will only be achieved with the active support of our stakeholders and local people.

To ensure this level of integration really exists, yet without undermining the divisional, clinical-led structures which are in place, a structured Programme Management Office (PMO) will be introduced. This office will ensure that plans are delivered on time and safely; and when investment is required to make change possible, a real return on that investment is delivered. In addition, the programme as outlined will be consistently communicated to staff and, wherever possible, these same staff empowered to make the necessary changes.

The financial programme will also support this work and this is exemplified by the capital investment programme. This includes a three year modernisation programme to provide 'best of breed' Electronic Patient Record (EPR) information sharing facilities across the local health community and the provision of robust infrastructure that will give access to high performing systems and accurate and timely information.

Response 4 - Establishing strategic alliances with likeminded provider partners

Whilst being cognisant of competition rules, the Trust plans to progress appropriate strategic alliances across South West Yorkshire Partnerships NHS Foundation Trust; Airedale NHS Foundation Trust; Mid Yorkshire Hospitals NHS Trust; and Locala Community Partnerships and other relevant providers.

The reason for this is two-fold, we are moving to an era of full on specialist commissioning which is evidenced in the most recent funding shift from local Clinical Commissioning Groups to Specialist Commissioners as a part of the national 'Everyone Counts: Planning for Patients 2013/14'. Whilst our Trust only has a comparatively small level of direct funding from specialist commissioning activity the reality is that certain commissioning decisions can have a domino effect on District General Hospital care such as we currently provide. In short the effect that a Specialist Commissioning focus on large regional centres can have is the reduction of the provision of local services for local people.

It is also the case that the reality of reducing resources for all public sector providers into the future makes collaboration for better patient safety and care a must.

Quality Improvement in the Trust

The Trust continues working to deliver the quality improvement strategy, improving the care we provide by reducing waste, encouraging innovation and paying attention to what patients are telling us about their experiences of care.

During this year the Trust has re-aligned the work contained in the strategy to the NHS Outcomes Framework to ensure we are focusing on the issues that matter and tied in the national agenda for improving the NHS. We have improvement collaboratives working on key processes and clinical outcomes, delivered using quality and service improvement tools.

Within the collaboratives the work is led by clinical champions and any potential changes are tested out in the areas where they are to be applied. Trust executives and senior managers support the work to ensure proven changes are spread and embedded into practice across the Trust.

The Trust has focused on building capacity and knowledge, teaching improvement and change management skills and embedding these into everyday practice.

The Trust continues the association with the Lean Enterprise Academy. Implementation of 'Visual Hospital' across both sites has made some real inroads into reducing the unnecessary waits that patients experience as inpatients. In the last 12 months the Trust has been working on implementing the next phase of work which is 'Plan for Every Patient' on all medical and surgical wards. The purpose of this is to ensure that patients get what they need both on time and in full. Whilst this is still work in progress the Trust is starting to see results.

Measurement and knowing how the Trust is performing against national indicators and internal targets is the key to improvement. Linked to this is the use of information we have from when things go wrong, from complaints, incidents and concerns, focusing on why this happens using root cause analyses. Where problems are highlighted they are reported and acted upon at the relevant divisional-level quality and safety board.

Examples of learning from complaints/incidents

- Additional training in A&E for all staff around the care needs of elderly patients with dementia
- Work is underway to improve the patient journey for patients with acute gall bladder symptoms resulting in more patients being operated on whilst an acute admission (if clinically appropriate) rather than being put on an elective waiting list.
- All wards are reviewing their discharge planning process and developing an action plan to improve discharge for all patients.
- Restrictions regarding visiting hours have been reviewed and where patients are critically ill no restrictions will be in place.
- The Stroke Team is developing a red care plan file for patients to take home with them, providing stroke patients with all the information they need to understand their stroke.

IT Modernisation Programme

Information technology is central to achieving long term sustainable quality improvement. A five year programme to modernise all aspects of how the Trust works with the use of technology has been launched this year.

The programme will see transformations in all areas from patient flow to medical records and maternity to theatres with the use of better, more effective, technology.

The changes will have an impact on all staff, both clinical and non-clinical.

The aim of this programme is to improve the experience of both patients and staff by ensuring that the Trust is making the best use of technology in all working areas.

It is a far-reaching programme of change that will impact on everyone at the Trust but will essentially result in better, more cost effective working as well as improving patients' experience of our service.

A clinical reference group will work alongside IT to ensure new technology fully supports best clinical practice but staff from all parts of the Trust will be asked to engage with the IM&T Modernisation Programme to ensure it is a success.

How we performed against the six priorities we set for 2012/13

The Trust is constantly scrutinising the quality of the services it provides to patients and looking for opportunities to make improvements.

Under the banner 'Safe, Effective and Personal' the Trust is focusing on key priority areas for improvement to ensure that our patients receive the best quality care that can be provided and continue to choose the Trust to receive that care.

Last year the Trust identified six quality improvement priorities for 2012/13. This section of the quality account shows how the Trust has performed against each of these priorities.

Improvement priority	Were we successful in 2012/13?
Reducing the number of pressure ulcers	Yes
Reducing the number(s) of healthcare associated infections - Methicillin -resistant Staphylococcus aureus (MRSA) Bacteraemias	Yes
Reducing hospital readmissions	Partially. We have seen an improvement but unfortunately we have not met our target.
Improving the care of patients with dementia	Yes
Improving doctors' communication with patients	Yes
Improving patient information on discharge	Yes

Priorities

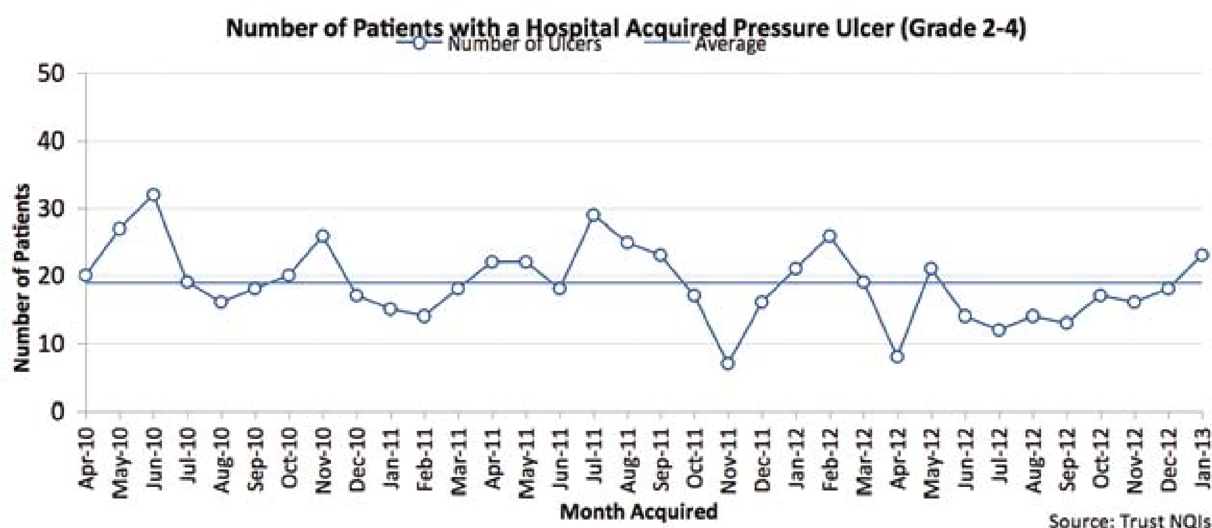
Priority one: Reducing the numbers of pressure ulcers

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

The incidence of pressure ulcers remains one of the key indicators of nursing quality and as such is a key improvement target for the Trust.

Throughout this year the Trust has continued to implement evidence-based prevention strategies and ensure staff have the knowledge and skills required.

We said we would 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.



The above chart shows the Trust has had 157 patients with hospital acquired pressure ulcers (April 2012 to January 2013), a reduction from 245 in 2011/12.

The SKIN bundle (Surface, Keep moving, Incontinence, and Nutrition) and intentional rounding are two of the key improvement tools used. They have been introduced to all adult medical and surgical wards and the Trust has ensured staff understand how these simple tools can have real benefits for improving patient safety, including reducing the incidence of pressure ulcers. The Trust has re-designed some of the paperwork following suggested improvements from the ward staff and we are now in the process of introducing an adapted SKIN care bundle.

To truly understand the barriers to safe practice, and to design some new interventions, the Trust has spent time working closely with a few wards. Learning from this work is now being spread to other wards.

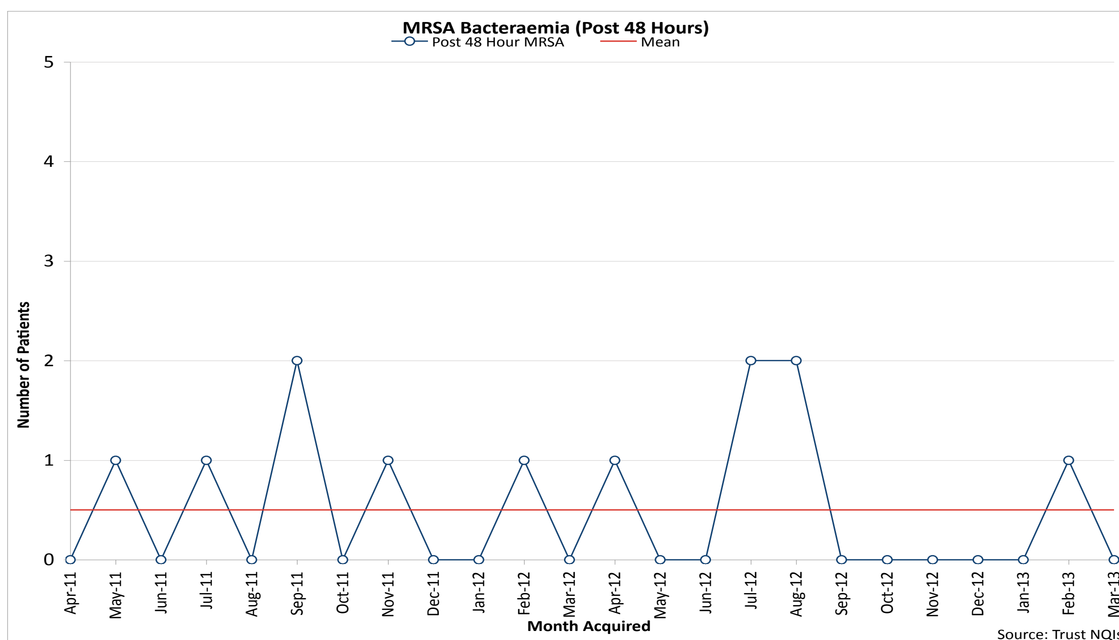
Priorities

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

Healthcare associated infections occur as a result of treatment provided or contact with a healthcare environment. MRSA is a bacterial infection that does not respond to certain antibiotics and it is, therefore, harder for us to treat.

The Trust continuously strives to reduce the number of healthcare associated infections by understanding why infections occur and sharing this learning with the clinical teams. To ensure practice is of the highest standard the Trust is applying the latest knowledge around reducing infections.

The objective for 2012/13 was to reduce the number of post-48 hour MRSA bacteraemias to four or less, an improvement on the six bacteraemias the Trust had in 2011/12.



The Trust has met the target of four post-48 hour MRSA bacteraemias. Despite this, the Trust is actively working to reduce the number further. Improvement work has focused on the following areas:

- Appropriate use of invasive devices (e.g. catheters and cannulas);
- Effective use of isolation;
- Giving staff the knowledge to prevent infections and confidence to actively challenge poor practice and promote best practice.

What is bacteraemia?
Bacteraemia is the presence of bacteria in the blood. Bacteraemia may occur through a wound or infection, or a surgical procedure or an injection. Bacteraemia may not cause any symptoms and resolve without treatment, or it may produce symptoms of infection such as fever. Lots of different types of bacteria live on the surface of the skin, urinary tract and other internal surfaces of the body. These bacteria are normally harmless because they are kept in check by the body's immune system. People in good health with strong immune systems rarely develop bacteraemia ,however, when bacteria is introduced into the circulatory system, particularly in a person who is unwell or undergoing aggressive medical treatment, the immune system may be unable to cope.

"It's been the hardest nine months of our lives yet the staff have been there for us every step of the way"

Paul Bottomley on his wife's cancer care.

Priorities

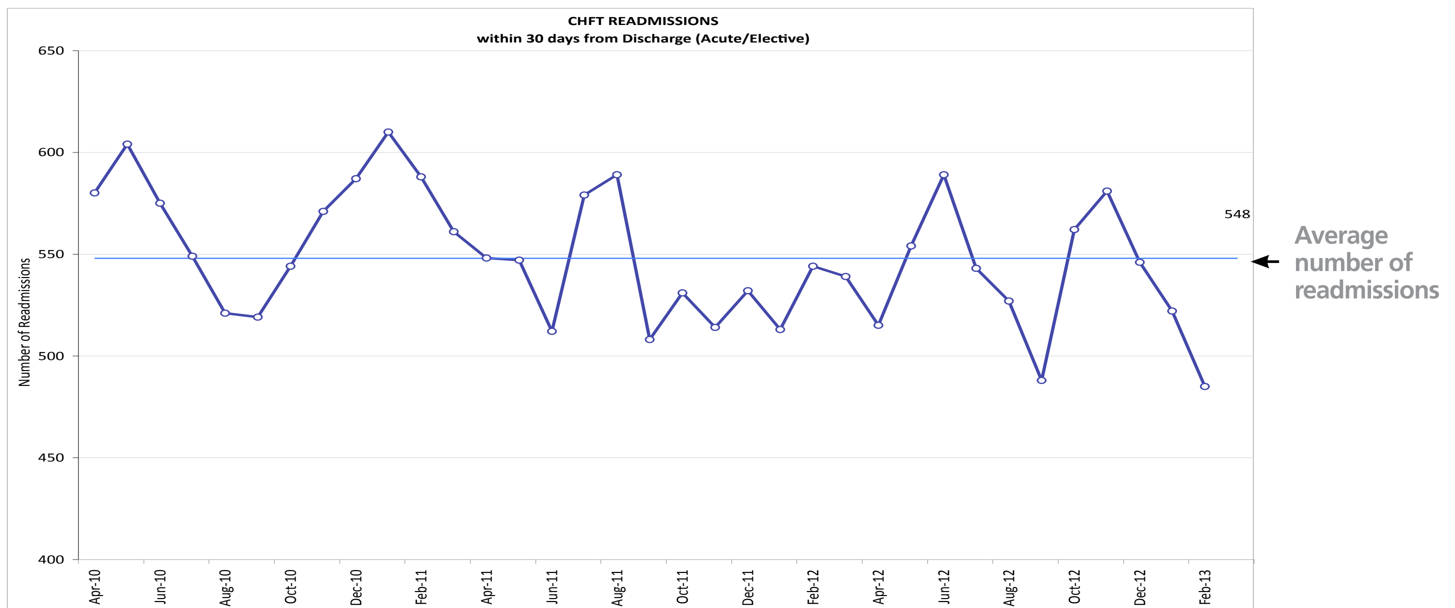
Priority three: Reducing hospital readmissions

The causes of readmission are complex. They can relate to the care patients receive after they leave hospital or unforeseen changes to a patient's condition as well as the quality of care in hospital before discharge. There is evidence that patients who are readmitted have a longer length of stay than for first admissions and, therefore, reducing readmission rates can help to reduce average length of stay in hospital.

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

By better planning and working together with patients and their carers the Trust can reduce the chance of readmissions. Therefore the focus of this work has been around improving our discharge planning process and improving support for patients after they leave hospital.

The Trust has been working to a target of reducing the number of avoidable readmissions by a third, year on year over the next three years beginning with this year.



So far the Trust has seen a reduction of 40 patients returning to hospital following an acute admission compared to last year, despite a 3% increase in the number of acute admissions.

This is why the Trust has continued throughout the year to operate and develop the 'Readmissions Virtual Ward', supporting patients after they have been discharged from hospital. Learning why patients return to hospital has also been a key part of this work. The Trust has also been working with community partners to ensure care is given at the right time in the right place.

When asked to comment on their hospital experience one patient said:
"Good medical and nursing care and also excellent personal care from nursing auxiliaries during period of hospital stay. Follow up of specialist nursing team after discharge which I thought was of a high standard"

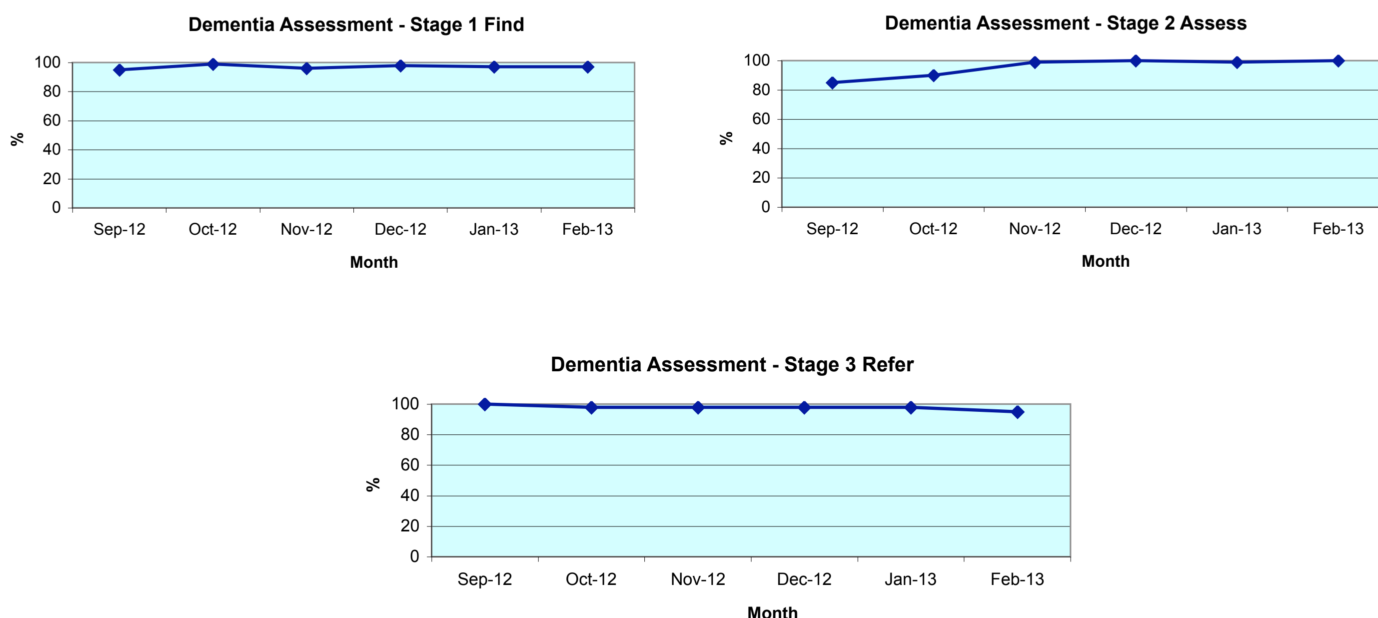
Priorities

Priority four: Improving the care of patients with dementia

Dementia is a syndrome (a group of related symptoms) associated with an ongoing decline of the brain and its abilities. Symptoms may include memory loss, mental agility, thinking speed, language, understanding and judgement. Around one in 100 people over 65 have dementia, six in 100 for people in their late 70s, and 20 in 100 for people in their late 80s.

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

The target for 2012/13 was to achieve compliance with all elements of the dementia Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN system was introduced in 2009 to make a proportion of providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care. The dementia CQUIN was new for 2012 and this target required the screening of all eligible patients for possible dementia and the notifying of GPs for further tests when needed. The Trust is required to achieve at least 90% compliance with the CQUIN target in three consecutive months.



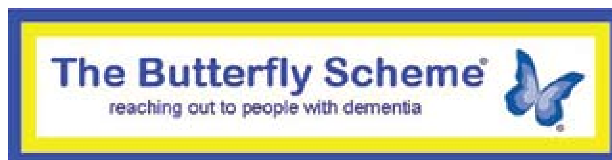
This year the Trust has met all elements of the dementia CQUIN. Moving forward we will continue to embed this change and ensure it is sustained.

In addition, the Trust has also been working on making the hospital environment safer for patients with dementia in the ongoing programme of ward upgrades.

There is a continuing programme of developing dementia champions on the wards to ensure care is of the highest standard and sharing that knowledge with colleagues to ensure all staff understand how to care for patients with dementia safely. This work is being linked to improvements to nursing documentation to ensure there are the prompts needed to help staff follow the process correctly.

The Trust has introduced and spread the 'Butterfly Scheme', an opt-in scheme for patients and carers identifying the patients with either delirium or confirmed dementia so all staff are aware of the extra help and care that may be needed. There is an ongoing awareness training programme around this scheme for clinical and non-clinical staff.

Priorities



Specialist care for patients with dementia
Patients with dementia 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 staff may need to introduce themselves and let patients know where they are each time they approach. People with memory-impairment may also have sleeping routines or food preferences they are not able to communicate to staff, but the scheme ensures that those details are available for all staff to access.

The 'Butterfly Scheme' helps overcome many typical difficulties, making the patient's hospital stay much better for both patients and staff. It is an opt-in scheme, but it is rarely turned down; family carers are delighted to work in partnership with the hospital team. The system works by a discreet 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, porters and all staff who have contact with the patients are also being trained.

Pictured Nurse Consultant for Older People Barbara Schofield (right), with the Butterfly Scheme founder Barbara Hodkinson

Priorities

Priority five: Improving doctors' communication with patients

This is a priority that was 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.

The Trust target for 2012/13 was to test, refine and spread current and further interventions to improve doctors' communication with patients.

Real Time Patient Monitoring (RTPM) involves asking patients a set of generic questions from the National Inpatient Survey before they leave hospital. RTPM provides feedback from patients that can be related to specific wards and teams, providing useful benchmarking data that can be used to identify areas of the service requiring improvements. The data below shows the aggregated scores taken from the RTPM data over the last three years and shows a year on year improvement in the scores that are being achieved. The maximum score that can be achieved is 10.

A composite indicator is defined as: a group of different but related indicators where data is combined and weighted leading to one overall score. For example, for doctors' communications, indicators for understanding answers to questions from doctors and explanations of procedures before and after are measured and the results combined result in one overall score.

RTM Quarterly Report – Q4 2012/13

RTM target: Trust composite indicator score on green/amber threshold (i.e. top 20%)

Baseline Score = 8.2 / Current = 8.9 / Target = 9.0

All scores have been compared against National Inpatient Survey 2012 thresholds which have been offset by +0.7 to account for differences in survey methodology

Inpatient RTM Doctors' Communication Questions – Directorate Level

BASELINE YEAR (2010/11)

	Surgery				Medicine & Elderly		CWS	TRUST	Threshold Boundaries	
	Accident & Emergency & Trauma	General & Specialist Surgery	Orthopaedics	Head & Neck	Acute Medical	Integrated Medical Specialities	Women's Services			
Sample size:	255	372	270	80	1277	95	140	2510		
When you had important questions to ask a doctor, did you get answers that you could understand?	8.3	8.3	8.1	8.5	7.9	8.5	8.4	8.0	8.6	9.1
Beforehand, did a member of staff explain what would be done during the operation or procedure?	9.0	9.0	8.6	8.6	8.7	8.7	9.3	8.8	9.0	9.4
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	8.4	8.3	7.9	7.0	8.1	7.6	8.4	7.9	8.2	8.8
COMPOSITE INDICATOR	8.6	8.5	8.2	8.0	8.2	8.3	8.7	8.2	8.6	9.1

LAST YEAR (2011/2012)

	Surgery				Medicine & Elderly		CWS	TRUST	Threshold Boundaries	
	Accident & Emergency & Trauma	General & Specialist Surgery	Orthopaedics	Head & Neck	Acute Medical	Integrated Medical Specialities	Women's Services			
Sample size:	255	372	270	80	1277	95	140	2510		
When you had important questions to ask a doctor, did you get answers that you could understand?	8.1	8.5	8.4	8.9	8.0	9.1	9.1	8.3	8.6	9.1
Beforehand, did a member of staff explain what would be done during the operation or procedure?	8.6	8.6	8.9	9.0	8.6	9.4	9.2	8.8	9.0	9.4
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	8.1	8.7	8.3	8.3	7.8	8.6	8.8	8.2	8.2	8.8
COMPOSITE INDICATOR	8.3	8.6	8.5	8.7	8.1	9.0	9.0	8.4	8.6	9.1

CURRENT YEAR (2012/2013)

	Surgery				Medicine & Elderly		CWS	TRUST	Threshold Boundaries	
	Accident & Emergency & Trauma	General & Specialist Surgery	Orthopaedics	Head & Neck	Acute Medical	Integrated Medical Specialities	Women's Services			
Sample size:	255	372	270	80	1277	95	140	2510		
When you had important questions to ask a doctor, did you get answers that you could understand?	9.2	8.8	8.9	9.4	8.7	9.0	9.5	8.9	8.6	9.1
Beforehand, did a member of staff explain what would be done during the operation or procedure?	9.0	9.5	9.1	9.4	8.8	9.6	9.7	9.2	9.0	9.4
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	8.7	9.0	8.6	8.7	8.2	9.4	9.4	8.6	8.2	8.8
COMPOSITE INDICATOR	9.0	9.1	8.9	9.2	8.6	9.3	9.5	8.9	8.6	9.1

Priorities

The Trust has increased the numbers of Divisional and Specialty champions for the DECS programme (Delivering Excellent Communication skills).

An in-house training event has been developed and delivered to a first cohort of doctors, with a second session planned for April 2013.

'Dear doctor' notes are in use to give patients an opportunity to document the most important issues they wish to discuss with the doctor at the next ward round and PLEASE posters are now displayed in all outpatient areas – these act as a prompt for both the patient and doctor about what to expect from an outpatient consultation.

The charts demonstrate that improvement has been seen in the three RTPM survey questions, increasing from a composite score of 8.2 in the baseline year (2010/11) to a current score of 8.5, with an improvement achieved for each of the three individual questions. The Trust will continue to work with staff to ensure this improvement continues.

"The nurses were very friendly and kind. The consultants were also very friendly"

Priorities

Priority six: Improving patient information on discharge

It is essential patients have the correct information about their ongoing care and treatment once they have left hospital. This will enable them to have the best and quickest recovery possible and will reduce the chance of them having an unexpected readmission to hospital. As a result this contributes to an overall good experience and increased confidence in the care they receive.

The aim was to monitor data at individual ward level to ensure improvements are sustained and to take remedial action as required to improve the scores in 2012/13.

Discharge 2012/2013

RTM Quarterly Report – Q3 2012/13

RTM target: Trust composite indicator score on green/amber threshold (i.e. top 20%)

Baseline Score = 7.5 / Current = 8.8 / Target = 7.8

All scores have been compared against National Inpatient Survey 2011 thresholds which have been offset by +0.7 to account for differences in survey methodology

Inpatient RTM Discharge Questions – Directorate Level

BASELINE YEAR (2010/11)

	Surgery				Medicine & Elderly		CWS	TRUST		
	Accident & Emergency & Trauma	General & Specialist Surgery	Orthopaedics	Head & Neck	Acute Medical	Integrated Medical Specialities	Women's Services		R-A	A-G
Sample size:	164	362	293	96	988	75	65	2606		
Do you feel you are involved in decisions about your discharge from hospital?	8.0	7.9	7.8	7.7	7.9	8.2	9.6	7.9	7.3	8.0
Has a member of staff explain the purpose of the medicines you are to take at home in a way you could understand?	8.7	8.6	8.6	9.5	8.2	9.1	10.0	8.5	8.7	9.3
Has a member of staff told you about medication side effects to watch out for when you are at home? (National CQUIN)	7.3	6.8	6.3	6.5	6.0	8.3	9.0	6.3	5.0	5.8
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	7.7	7.2	6.7	7.9	7.5	7.9	8.5	7.2	6.0	6.9
Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital? (National CQUIN)	8.8	8.3	7.5	8.1	7.6	9.1	9.1	7.8	7.9	8.8
COMPOSITE INDICATOR	8.1	7.8	7.4	7.9	7.4	8.5	9.2	7.5	7.0	7.8

LAST YEAR (2011/2012)

	Surgery				Medicine & Elderly		CWS	TRUST		
	Accident & Emergency & Trauma	General & Specialist Surgery	Orthopaedics	Head & Neck	Acute Medical	Integrated Medical Specialities	Women's Services		R-A	A-G
Sample size:	284	420	285	87	1406	98	86	2904		
Do you feel you are involved in decisions about your discharge from hospital?	8.6	8.7	8.5	8.5	8.6	8.8	9.4	8.6	7.3	8.0
Has a member of staff explain the purpose of the medicines you are to take at home in a way you could understand?	9.3	8.9	9.0	9.4	8.6	9.4	9.5	8.9	8.7	9.3
Has a member of staff told you about medication side effects to watch out for when you are at home? (National CQUIN)	8.0	7.8	7.0	7.1	6.8	8.5	8.0	7.3	5.0	5.8
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	8.0	7.7	7.4	7.8	8.1	7.6	8.0	7.8	6.0	6.9
Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital? (National CQUIN)	8.8	8.2	8.0	8.8	7.9	9.3	8.9	8.2	7.9	8.8
COMPOSITE INDICATOR	8.5	8.3	8.0	8.3	8.0	8.7	8.8	8.2	7.0	7.8

CURRENT YEAR (2012/2013)

	Surgery				Medicine & Elderly		CWS	TRUST		
	Accident & Emergency & Trauma	General & Specialist Surgery	Orthopaedics	Head & Neck	Acute Medical	Integrated Medical Specialities	Women's Services		R-A	A-G
Sample size:	147	249	187	58	589	65	97	1406		
Do you feel you are involved in decisions about your discharge from hospital?	8.3	8.9	8.8	8.7	8.6	8.6	9.6	8.7	7.3	8.0
Has a member of staff explain the purpose of the medicines you are to take at home in a way you could understand?	9.4	9.2	9.1	9.8	8.7	9.5	10.0	9.1	8.7	9.3
Has a member of staff told you about medication side effects to watch out for when you are at home? (National CQUIN)	7.9	8.0	7.3	8.0	7.4	8.4	9.2	7.7	5.0	5.8
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	7.9	8.0	7.9	8.6	8.1	7.9	9.3	8.1	6.0	6.9
Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital? (National CQUIN)	9.4	9.3	8.6	9.5	8.4	9.5	9.2	8.8	7.9	8.8
COMPOSITE INDICATOR	8.6	8.7	8.3	8.9	8.2	8.8	9.5	8.5	7.0	7.8

Priorities

Individual ward based scores are received quarterly by ward sisters and matrons.

A communication campaign has been undertaken to raise the importance of timely discharge information and a discharge collaborative has been established.

The Trust has continued to promote the use of the discharge proforma by all wards and increased the presence of ward-based pharmacists.

The charts demonstrate that improvement has been seen in the five discharge inpatient RTPM survey questions, increasing from a composite score of 7.5 in the baseline year (2010/11) to a current score of 8.5, with an improvement achieved for each of the five individual questions.

Information on discharge is key to safe discharge and reducing emergency readmissions and this is why it continues to be an important area of work.

Your Care Our Concern

Calderdale and Huddersfield NHS
NHS Foundation Trust

INFORMATION FOR YOUR DISCHARGE FROM HOSPITAL

On discharge from hospital following your recent stay general advice about your care and treatment will be given to you by the nursing staff before you leave the ward. If there is anything which still concerns you please ask a nurse or Doctor before you leave the hospital. An appropriate place can be found if you need privacy to discuss any concerns.

However, if when you get home you have any worries about your condition / treatment please contact:

Your GP (even in out of hours periods, as there is a duty service)	
Your District Nurse	
The ward on	
Other (must be specified at discharge time e.g. CPN, community matron)	

Your Medication/Tablets on Discharge

On discharge you may be given tablets, medicines or inhalers, etc, to take at home. Your medicines will contain advice leaflets and/or instructions on how to take them. If you already use a Dosette box please make us aware.

Before you leave hospital a Nurse / Doctor or Pharmacist will provide the following information about your medicines. This will be in a way that you understand

- Why you are taking your medicines
- Possible side effects to watch out for
- How to take your medication correctly
- Additional clear, printed information about your medicines

If you are unsure about anything to do with your medication, please ask a Nurse /Doctor or Pharmacist to explain it to you before you leave hospital.

If when you get home you have further questions about your medicines please telephone the Pharmacy department Monday – Friday (except bank holidays) between 10am and 4pm. Please telephone the hospital that you have been discharged from; Calderdale Royal Hospital pharmacy 01422 224355 or Huddersfield Royal Infirmary pharmacy 01484 342131. Alternatively you can visit the NHS choices website: http://www.nhs.uk/medicine-guidelines/pages/default.aspx

General Care on Discharge

The nurse discharging you will also provide you with verbal, written or printed information on the following:

- Signs or 'danger signals' for you to look out for following your discharge (e.g. feeling feverish or swelling)
- What you should or should not do after leaving hospital
- What your family / someone close can do to help care for you
- How to care for your wound/s
- How to manage your pain

If you think your concerns are urgent, or an emergency situation arises, you should contact either NHS Direct on 0845 4647 or Dial 999 for an emergency ambulance.

We hope that all goes well with your planned discharge and offer our best wishes to you.

Signed: **Designation:** **Date:**

Looking ahead to 2013/14

The content of the Robert Francis report, published in February 2013, highlighting lessons learnt from poor quality care provided at Mid Staffordshire NHS Foundation Trust was debated by the Trust Board of Directors. It was agreed that the Trust would accept the content and recommendations of the Francis report in its entirety. A further piece of work would be undertaken to also incorporate the Government's response to Francis. The priorities set out for this coming year support directly or indirectly many of the recommendations arising from this report.

This year the Trust has put together a long list of potential quality improvement priorities by:

- Evaluating our performance against our priorities for 2012/13;
- Looking at national priorities and things we have agreed with our commissioners (Clinical Commissioning Groups) as part of Commissioning for Quality and Innovation (CQUIN);
- Considering the priorities in 'Everyone Counts: Planning for Patients 2013/14' and the 'NHS Outcomes Framework 2013/14' - both documents shape our approach;
- Listening to what our regulators had identified as a priority;
- Taking into account reports and issues raised by organisations such as the Patients Association.

The Trust then asked patients, staff, Foundation Trust members, the general public, the local involvement networks (LINks) in Calderdale and Kirklees, local authority overview and scrutiny panels, the local mental health Trust, health and wellbeing boards and clinical commissioning groups what they thought the priorities should be for 2013/14.

This year 202 foundation trust members completed and returned the survey leaflets that were distributed with our Foundation Trust newsletter and 115 people completed the online survey in full, including 40 staff members, 35 Foundation Trust members and 37 members of the public.

This work has helped identify the following quality improvement priorities for 2013/14 because they are important to the Trust's stakeholders.

- Healthcare associated infections
- Appropriate and safe discharge
- Care of patients with dementia
- Reducing healthcare acquired pressure ulcers
- Helping people to manage their long-term conditions

Improving doctors' communication with patients will not be taken forward as a priority for the Quality Account this year. This does not mean that the work is complete – it will continue alongside many other areas identified in our quality improvement strategy. The Trust recognises that communication between staff and their patients is paramount to ensuring a good patient experience. The Trust will continue to monitor this through our real time patient monitoring.

Improving patient information on discharge becomes part of the Trust's improvement priority of appropriate and safe discharge.

Looking ahead to 2013/14

Healthcare associated infections

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

In summary the Trust has selected this indicator because:

- Continuity from 2012/13
- High profile national target

Improvement work
Improvement work will continue to focus on hand hygiene, effective and consistent cleaning of equipment and the environment, care and management of invasive devices, blood culture competency and good antibiotic stewardship.

Target
The ceiling target for 2013/14 for reduction of clostridium difficile is 28 and there is a national zero tolerance for all avoidable cases of MRSA.

Reporting
The Trust continues to measure 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 performance and reports on this to the Executive Board.

The Trust will also be reporting progress against the targets set out in this Quality Account on a quarterly basis to the Quality Assurance Board.

Pressure ulcers

Why we chose this
This priority has been carried forward to ensure the Trust maintains focus and pace of improvement to reduce the number of patients who develop pressure ulcers. The number of pressure ulcers remains an important measure of quality and this year the Trust will also be including community acquired pressure ulcers in the improvement work and reporting. The pressure ulcer collaborative work links closely with the transparency work that has been implemented across the Trust. Learning from investigations of pressure ulcers and patient and staff feedback will be incorporated into the work of the collaborative in the forthcoming year.

In summary the Trust has selected this indicator because:

- Continuity from 2012/13
- High profile national target

Improvement work
The Trust will continue to implement the two key improvement tools, the SKIN care bundle and intentional rounding, that have been implemented during the past year.

The pressure ulcer collaborative team is working closely with individual wards to tailor education, training and interventions to their specific needs. Learning from these wards and the additional tools developed to support wards will be shared across the Trust.

The Trust has learnt that there are several basic actions all wards can take quickly to ensure they are delivering best practice, these have been developed into a tool 'Seven steps to pressure ulcer prevention'. This is being implemented across the Trust.

The process for reducing pressure ulcers in the community is different than for hospital wards, the Trust will be carrying out a specific piece work to design and test interventions that work in practice. In addition collaborative working across the health economy continues e.g. the nursing home project in Calderdale Nursing Homes.

Target
The Trust target is to achieve the 2013/14 CQUIN for Pressure Ulcers (linked to the Safety Thermometer).

The target is to achieve a 5.5% or lower harm rate for pressure ulcers (as measured through monthly point prevalence audit using the national Safety Thermometer tool). Please note this figure includes all pressure ulcers reported.

Reporting
The Trust 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 part of the integrated performance report to the Board of Directors and Executive Board each month.

The Trust will also be reporting progress against the targets set out in this Quality Account on a quarterly basis to the Quality Assurance Board.

Appropriate and safe discharge

Why we chose this
Effective discharge planning is one of the key factors related to the quality of inpatient care, unnecessary hospital readmission and good patient experience. It is essential to ensure that patients have the correct information when they are discharged and have a point of contact should they be concerned about their condition in any way. It is important that patients feel confident when going home to ensure that their recovery is as uneventful as possible and unnecessary readmission is avoided.

In summary the Trust has selected this indicator because:

- Continuity from 2012/13
- Highest priority in consultation
- Information from complaints
- High profile national target

Improvement work
Recognising that hospital discharge can be a complex and challenging process for healthcare professionals, patients and carers a discharge collaborative has been established to work with a small number of test wards to identify areas where improvements to the process can be made.

Work will take place to ensure patients reliably have an estimated date of discharge on admission and are given medications for discharge in a timely manner along with information about their medications. A discharge sheet should also be given to patients on discharge informing them who to contact if they are worried. An electronic discharge summary should be sent to the patient's GP.

Target
The Trust will continue to work to reduce the number of avoidable readmissions by continued improvement of the discharge process. The aim is to achieve a sustained reduction in readmissions through 2013.

Reporting
The discharge collaborative is directly accountable to the Improving Patient Experience Steering Group which in turn reports to the Quality Improvement Board and, by exception, to Executive Board. The Trust will measure performance through the Real Time Patient Monitoring which will be reported through the above group. Any interventions tested on the collaborative wards would be measured for reliability.

The Trust will also be reporting progress against the targets set out in this Quality Account on a quarterly basis to the Quality Assurance Board

Looking ahead to 2013/14

Dementia

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

In summary the Trust has selected this indicator because:

- An existing priority
- Very important to partners
- A strong national agenda

Improvement work
Throughout the next year the Trust will be continuing to deliver the dementia assessment 'find, assess, investigate and review' (FAIR) process; aiming to reliably achieve 90% and above each month for patients being assessed.

The Trust will be continuing to roll out the butterfly scheme to bring benefits and improve the safety of care for patients with dementia. As part of this the Trust will be delivering the ongoing training programme to support this work and further developing the role of ward-based dementia champions.

Moving forward the Trust is developing a process to assess the level of carer support, to learn from carer's experiences where the Trust could do better and start to implement any changes needed.

Finally the dementia collaborative will continue to influence the programme of ward refurbishment to ensure that changes made are dementia friendly to improve the safety of care for inpatients with dementia.

Target
The national CQUIN target is to ensure that 90% and above of all inpatients aged 75 and over have a FAIR assessment carried out and where indicated are referred to GPs on discharge for further assessment.

The local CQUIN target is to ensure the Trust maintains 90% and above for all inpatients admitted through Medical Assessment Units and Surgical Assessment Units combined who are 65 years old and above.

The Trusts training target is that by the end of the year we have 90% of wards with at least one dementia expert in situ, and 75% of wards to have one competent dementia lead in place.
For carer support the trust aims to be able to demonstrate the work undertaken and to have conducted a series of carer interviews.

Reporting
Work on dementia is overseen and reported via the Dementia Board and then by exception to Executive Board. All CQUIN targets are reported externally to Department of Health (Unify system) and our Clinical Commissioning Group. The Trust will also be reporting progress against the targets set out in this Quality Account on a quarterly basis to the Quality Assurance Board.

Helping people to manage their long-term conditions

Why we chose this
There are many long term conditions defined as: health problems that can't be cured but can be controlled by medication or other therapies.

The Trust has been working with patients with Chronic Obstructive Pulmonary Disease (COPD) to develop and reliably implement two care bundles - one delivered on admission to ensure the correct treatments are given quickly and in full to aid quick recovery and the second designed to ensure these patients have a safe discharge from hospital to minimise the risk of readmission, ensure appropriate follow up and a good experience of care.

Improvements have been made in both aspects of this work but there is some further work to undertake in this area which is why the Trust is focusing on this priority.

In summary the Trust has selected this indicator because:

- High priority to our partners and patients
- Fit with Strategic Review. Strategic Review is a programme for change being led by local health and social care commissioners. The Trust is a partner in this programme.

Improvement work
The Trust will continue to deliver and improve the reliability of the two care bundles in place. This work includes ongoing measurement of compliance with each element and the bundles as a whole to better understand when the Trust fails to deliver elements, overcome any barriers to ensure reliability and change practice when needed.

The CQUIN target for 2012/13 was missed by just 5%, the Trust achieved 90% of all elements of the care bundle being delivered. Understanding why some patients did not get all the elements has provided the Trust with valuable learning and will help shape the work moving forward.

In addition to continuing to work closely with the specialist respiratory team, the Trust will be working with ward staff to ensure they have the skills required to deliver the bundle elements. The Trust will be building skills and confidence at ward level to own and deliver elements where appropriate, including to refer directly to the specialist respiratory team to inform them about any necessary follow-up care that has been identified.

This includes the possibility to take someone out of hospital early with the early supported discharge (ESD) team. The Trust will ensure that the WHOLE of the bundle is signed off and every element is completed before the patient leaves the ward. It is also essential that discharge summaries accurately reflect the notes with regard to a patient's suitability for services following discharge and the Trust will be working with medical staff to ensure this happens.

Target
The Trusts CQUIN target is to achieve 95% of patients receiving all elements of the discharge bundle within five working days of discharge from hospital. This will require the ward to generate a referral to the specialist respiratory nurses on confirmation of a diagnosis of COPD; this will be based either on past proven spirometory readings or new reports.

Reporting
The Trust reports monthly on this CQUIN performance to the Executive Board and the Board of Directors. In addition, the COPD collaborative leads on the improvement work to be carried out for both bundles, reporting through the clinical effectiveness arm of the Quality Improvement Strategy to the Quality Improvement Board. This will be delivered in collaboration with the community specialist respiratory team cross site.

The Trust will also be reporting progress against the targets set out in this Quality Account on a quarterly basis to the Quality Assurance Board

Statements of assurance from the board

Review of services
During 2012/13 the Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 41 relevant health services.

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

The income generated by the relevant health services reviewed in 2012/13 represents 37.52% of the total income generated from the provision of relevant health services by the Calderdale and Huddersfield NHS Foundation Trust for 2012/13

Participation in Clinical Audits
During 2012/13, 44 of the national clinical audits and five national confidential enquiries covered relevant health services that Calderdale and Huddersfield NHS Foundation Trust provides.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 98% of national clinical audits and 100% of national confidential enquiries in which it was eligible to participate.

Details can be found in Appendix A

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

The number of patients receiving relevant health services provided or sub-contracted by Calderdale and Huddersfield NHS Foundation Trust in 2012/13 that were recruited during that period to participate in research approved by a research ethics committee was 927.

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.

Calderdale and Huddersfield NHS Foundation Trust was involved in conducting 165 clinical research studies of which 83 were actively recruiting, 61 were closed to recruitment (but participants were still involved) and 21 studies were 'in set up' (either waiting for initiation or local approval).

During 2012/13 actively recruiting research studies were being conducted across 4 divisions in 17 specialties:

- Child and Family Services (11 studies, 4 specialties);
- Diagnostic and Therapeutic Services (3 infection studies);
- Medical Services (65 studies, 14 specialties);
- Surgical and Anaesthetic Services (9 studies, 4 specialties).

Over the same period two ethically approved basic science studies were being conducted in collaboration with the local university.

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

There were 64 clinical staff participating in research approved by a research ethics committee at Calderdale and Huddersfield NHS Foundation Trust during 2012/13, of which 40 were local principal investigators and one was chief investigator on an international multicentre clinical trial.

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

Goals agreed with commissioners
A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2012/13 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 (CQUIN) payment framework. The figure for CQUINs allocated for 2011/12 was £4,099,363 and for 2012/13 was £7.125m. The Trust successfully achieved all but one of the requirements for the 2012/13 CQUIN programme, the only element missed was for the Chronic Obstructive Pulmonary Disease (COPD) care bundle indicator and represents £0.2million.

The CQUIN areas identified for 2012/13 covered a broad range of areas and reflected those priorities specified at a national level and supported by local priorities identified in partnership between commissioners and the Trust.
Four National CQUIN areas were identified for 2012/13:

- Venous Thromboembolism (VTE) screening;
- Dementia screening and referral;
- Patient experience;
- NHS Safety Thermometer Harm Measurement Indicator.

These national areas were complemented by further locally agreed CQUIN indicators in the following areas:

- Chronic Obstructive Pulmonary Disease care bundle;
- Implementation of the Productive Community Programme;
- Transfer of care.

In planning for 2013/14 the Trust has continued to work closely with local commissioners to develop a programme of CQUIN quality indicators which are consistent with the key challenges faced locally. The development of these areas of focus has had strong clinical involvement in identifying areas for possible inclusion.

A number of 2012/13 CQUIN indicators have been retained and will enter a further year of targeted improvement work during 2013/14:

- Dementia (National);
- NHS Safety Thermometer (National);
- VTE (National).

A new national CQUIN indicator relating to the recently launched 'Friends and Family Test' will also begin during 2013/14. This area of work will initially focus on the patient response rate to the Friends and Family question.

The other locally agreed CQUIN areas for 2013/14 are:

- Maternity services and Paediatric patient experience;
- Respiratory including Asthma and Chronic Obstructive Pulmonary Disease (COPD);
- Diabetes: supporting the treatment of patients presenting acutely with hypoglycaemia and the promotion of self-care;
- Medicines reconciliation when patients are entering/leaving the organisation.

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 2012/13.

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

In August 2012 and January 2013 CHFT received improvement notices from CQC in relation to documentation.

The Trust received a notice of failure to comply with regulation 20(1) (a) Records dated 8th April 2013. An action plan is being implemented which includes introduction of large scale changes to the clinical documentation to better reflect the care given. All wards are undergoing weekly in depth audits of their clinical records, issues are dealt with as they arise and themes and general poor compliance actioned through a weekly clinical records board. In addition nursing and support staff are having refresher training on their responsibilities around documentation. For medical staff their responsibilities are likewise being highlighted via divisions and where poor practice is being picked up this is being addressed with the individual concerned. One key criticism was the differing versions and poor quality copying of our documentation, all new documentation is formally approved and is then given a unique identifier and uploaded to the documentation repository. This allows us to keep close control over versions and enables all paperwork to be printed avoiding poor quality copies.

Data quality
Calderdale and Huddersfield NHS Foundation Trust's Information Governance and Records Strategy Committee has approved a Data Quality Improvement Plan for 2013/14 which includes the following actions:

- Review of all systems to ensure compliance with the updated NHS Number Standard;
- Development and implementation of processes and procedures to ensure synchronisation of patient demographic data between the Trust's primary and secondary care patient systems;
- Implementation of automated real time check of patient demographic and GP data from the national spine for key inpatient and outpatient events;
- Continuation of development of data dictionary and system documentation to support key management data users;
- Review and update of data quality guidance notes for data collectors;
- Introduction of revised data quality reporting to Trust Executive Board;
- Ensuring pre-planned cycle of data quality audits meeting Information Governance Toolkit standards;
- Provision of data quality advice and input to roll out of ward whiteboards to support timely and accurate collection of inpatient activity data;
- Provision of targeted data collection training for key areas of concern;
- Support for process and system review to ensure RTT (referral to treatment time) data can be included in the Trust's central data submissions.

Statements of assurance from the board

NHS Number and general medical practice code validity

Calderdale and Huddersfield NHS Foundation Trust submitted records during 2012/13 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was:
  Admitted Patient Care = 99.8%
  Outpatient care = 99.9%
  Accident & Emergency Care = 98.6%

- Which included the patient's valid General Practitioner's Registration Code was:
  Admitted Patient Care = 100%
  Outpatient Care = 100%
  Accident & Emergency Care = 99.9%

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

Information Governance

Calderdale and Huddersfield NHS Foundation Trust Information Governance Assessment Report overall score for 2012/13 was 80% and was graded as 'Satisfactory' with all scores at a level 2 or 3.

In the submission of the Information Governance Toolkit for March 2013 the Trust scored 80% and was marked as 'Satisfactory'. All scores were either at a level 2 or a level 3. A substantial programme of work is under way for 2013/14 to promote the use of technology within the Trust. This will lead to an improvement in information security and much more awareness of staff of the Information Governance Agenda. There will be leaflets, road show events and visits to wards and departments across the Trust to interact with staff and ensure that all Information Governance standards are being adhered to.

Clinical Coding Error Rate

Calderdale and Huddersfield NHS Foundation Trust was subject to the payment by results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) were 3.27% against a national figure (based on 2011/12 data) of 7.5%.

The results should not be extrapolated further than the actual sample audited. The services that were reviewed within the sample were:

- Lobar pneumonia
- Unspecific chest pain
- Unspecific urinary tract infections

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

- Updating process for verifying coding of mortality
- Increased Clinical Engagement
- Education and awareness
- Improving the state of the case notes
- Exploring different technologies to capture the data

Review of quality performance – how we compare with others

In this section you will find more information about the quality of services that the Trust provides by looking at performance over the last year and how the Trust compares with other Trusts.
This year the Department of Health (DH) has published a core set of indicators to be included in the Quality Accounts of all NHS Foundation Trusts. These changes support the Mandate commitment that the NHS should measure and publish outcome data for all major services by 2015.

Summary table of performance against mandatory indicators

	Previous 2 Periods		Most Recent Period
12. Summary Hospital-Level Mortality Indicator (SHMI).	FY2011/12 Q4	FY2012/13 Q1	FY2012/13 Q2
(i) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	109.54	95.31	101.77
(ii) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period.	0.86%	0.78%	0.97%
18. PROMS; patient reported outcome measures.	2009/10	2010/11	2011/12
(i) groin hernia surgery,	0.07	0.10	0.10
(ii) varicose vein surgery,	0.12	0.09	0.09
(iii) hip replacement surgery, and	0.44	0.42	0.45
(iv) knee replacement surgery.	0.33	0.38	0.32
19. Patients readmitted to a hospital within 28 days of being discharged.	2008/09	2009/10	2010/11
(i) 0 to 14; and	11.5%	11.7%	11.1%
(ii) 15 or over.	10.8%	11.3%	12.4%
20. Responsiveness to the personal needs of patients.	2009/10 66	2010/11 65.9	2011/12 66.8
21. Staff who would recommend the Trust to their family or friends.	2010 -	2011 66%	2012 69%
23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	FY2012/13 Q2 90.3%	FY2012/13 Q3 91.5%	FY2012/13 Q4 93.6%
24. Rate of C.difficile infection.	2009/10 37.6	2010/11 25.1	2011/12 12.7
25. Patient safety incidents and the percentage that resulted in severe harm or death.	Apr 11 - Sep 11	Oct 11 - Mar 12	Apr 12 - Sep 12
(i) Rate of Patient Safety incidents per 100 Admissions	6.93	5.77	5.43
(ii) % of Above Patient Safety Incidents = Severe/ Death	1.6%	1.8%	2.5%

Review of quality performance – how we compare with others

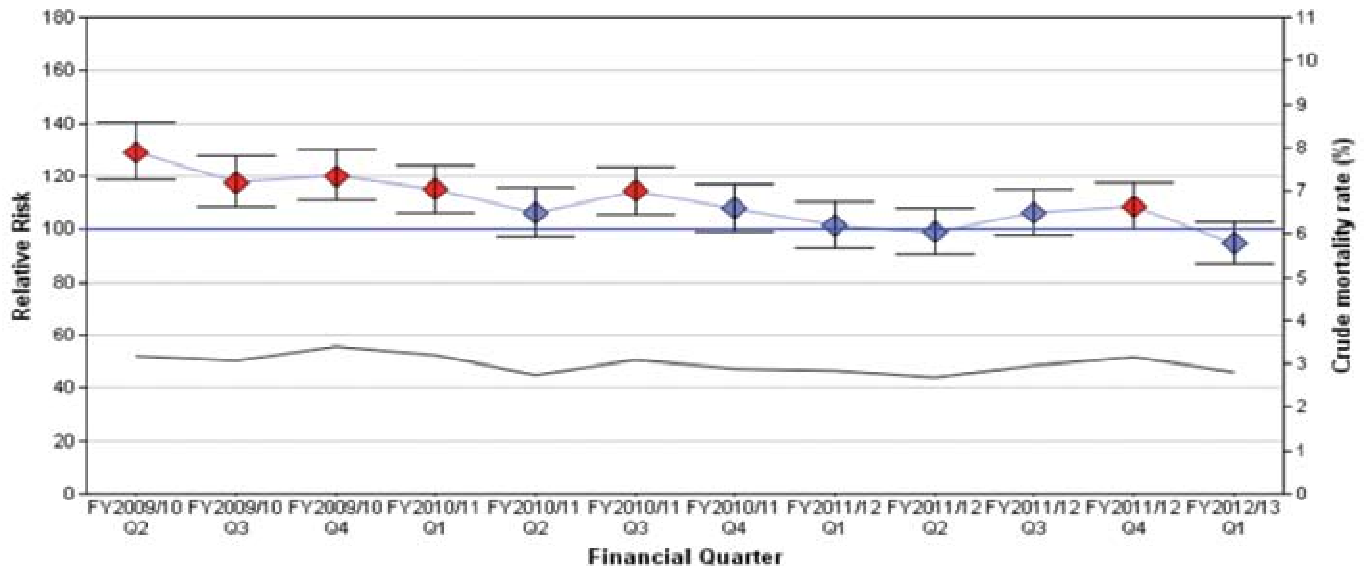
12. Preventing People from dying prematurely (i) Summary Hospital-Level Mortality Indicator (SHMI)

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

It covers all deaths reported of patients who were admitted to acute, non-specialist Trusts and either die while in hospital or within 30 days of discharge. The data used to produce the SHMI is generated from data the Trusts submit to the Secondary Uses Services (SUS) linked with data from the Office for National Statistics (ONS) death registrations to enable capturing of deaths which occur outside of hospitals.

SHMI gives an indication for each hospital Trust in England whether the observed number of deaths within 30 days of discharge from hospital was higher than expected, lower than expected or as expected when compared to the national baseline.

The chart below shows the value and banding of the SHMI for the Trust for the reporting period from July 2009 to July 2012.



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

SHMI by Provider (All Non Specialist Acute Providers) for all admissions in 2011/12

Relative Risk: 0, 20, 40, 60, 80, 100, 120, 140

Provider:
THE WHITTINGTON HOSPITAL NHS TRUST...
BARTS HEALTH NHS TRUST...
THE HILLINGDON HOSPITALS NHS FOUNDATION TRUST...
UNIVERSITY HOSPITAL SOUTHAMPTON NHS FOUNDATION...
SURREY AND SUSSEX HEALTHCARE NHS TRUST...
STOCKPORT NHS FOUNDATION TRUST...
NORTH BRISTOL NHS TRUST...
MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST...
COUNTY DURHAM AND DARLINGTON NHS FOUNDATION TRUST...
THE ROYAL WOLVERHAMPTON NHS TRUST...
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST...
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION...
YEOVIL DISTRICT HOSPITAL NHS FOUNDATION TRUST...
ROYAL BERKSHIRE NHS FOUNDATION TRUST...
ISLE OF WIGHT NHS PRIMARY CARE TRUST...
DERBY HOSPITALS NHS FOUNDATION TRUST...
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST...
GEORGE ELIOT HOSPITAL NHS TRUST...

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

- The SHMI data shows our performance against the expected mortality rate of 100. As you can see data available for the past 3 years does show some improvement.

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

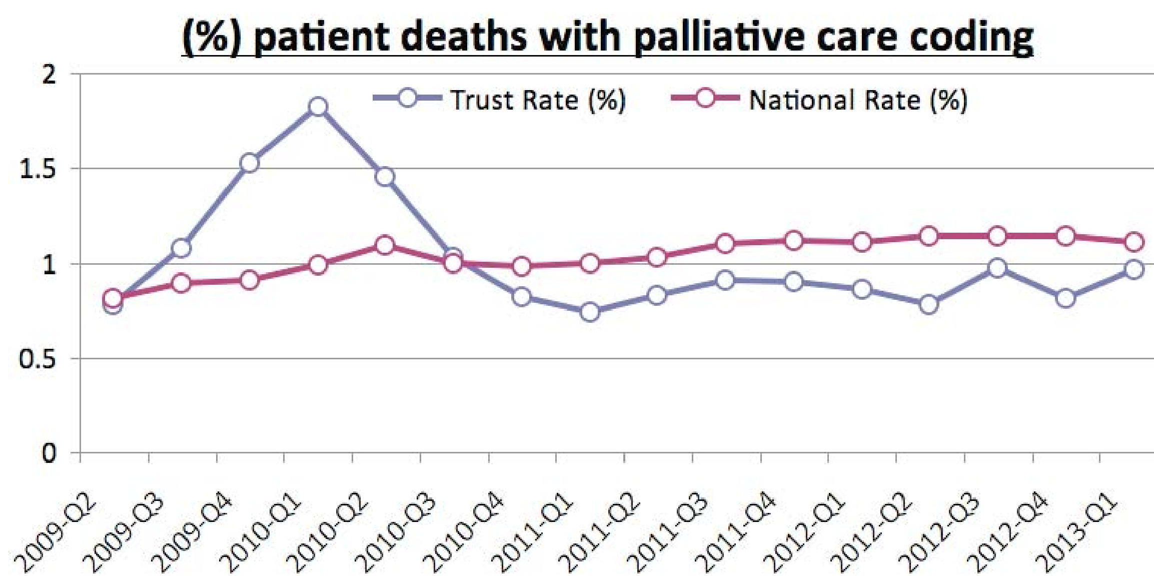
- By aligning patient safety initiatives to this aim, focusing improvement work on areas known to contribute to mortality such as patient falls and pressure ulcers. In addition the Trust uses the national tools available to us (Dr Foster and SHMI) to monitor where we have conditions with higher than expected mortality rates, looking at these cases and understanding the causes and using this knowledge to guide improvement work.

"How do I put this? For the second time, this team of people have saved my life. On the ball and professional all the time. Thank you all."

Review of quality performance – how we compare with others

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

The chart shows the percentage of Calderdale and Huddersfield NHS Foundation Trust hospital deaths that have a palliative care code against the national rate.
The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:



The Trust's performance against the national rate through 2009/10 was higher but this has now been resolved and since then the Trust has maintained its position at just below the national rate.

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

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

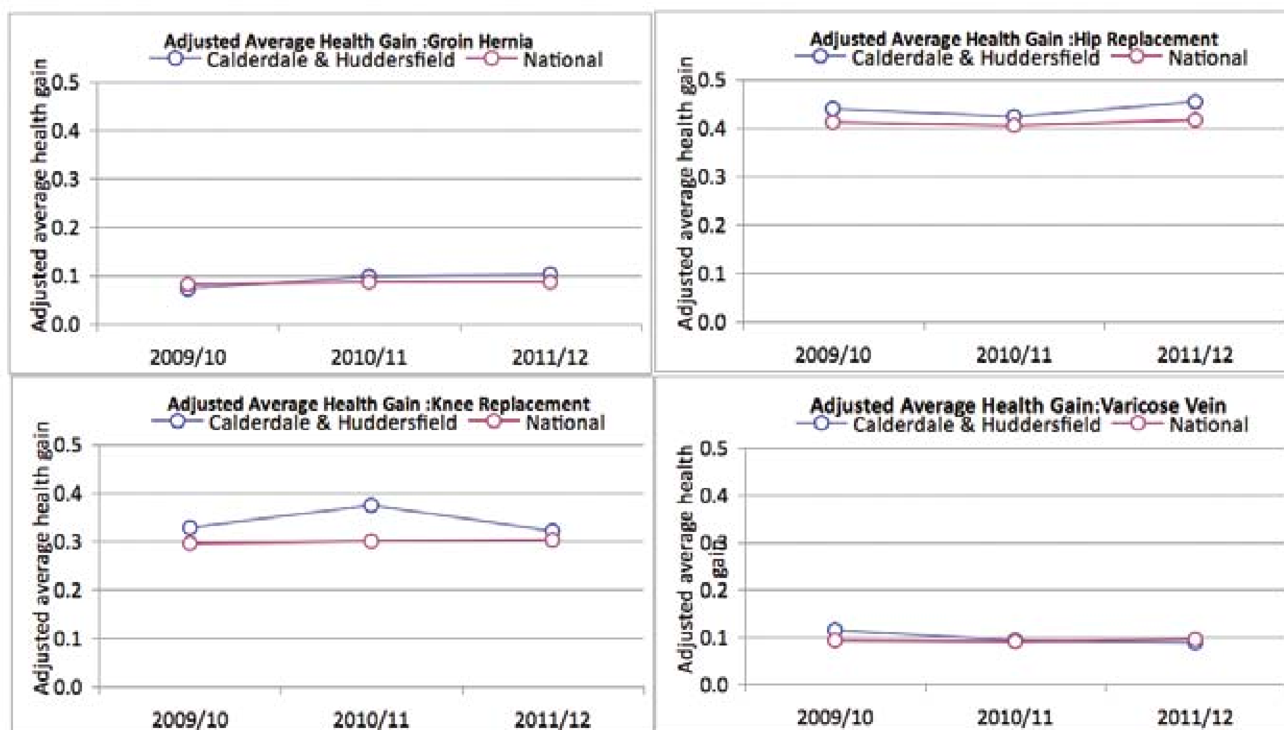
18. Helping people recover from episodes of ill health or following injury

PROMS are a way of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

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

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

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



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

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

- Participation:

Overall the participation rate for completing the questionnaire before the operation is higher for 2011/12 compared with 2010/11 across all four procedures' data. This also compares favourably to national data at 74% with Calderdale and Huddersfield NHS Foundation Trust at 88.2%.

Participation rate after the operation is 70.1% for England with Calderdale and Huddersfield NHS Foundation Trust at 69.4%; however, this has still time to improve when all the remaining questionnaires from patients are completed.

- Health Gain compared to national data:

Groin Hernia – Overall range 38.7% to 63.6% (Calderdale and Huddersfield NHS Foundation Trust – 51.6%, England 51.2%)
Hip Replacement – Overall range 77.6% to 100% (Calderdale and Huddersfield NHS Foundation Trust – 89.7%, England 87.5%). The Trust is a positive outlier for hip replacement health gains when compared to national data.
Knee Replacement – Overall range 69.3% to 95.8% (Calderdale and Huddersfield NHS Foundation Trust – 84.3%, England 79.1%) The Trust is a positive outlier for knee replacement health gains when compared to national data.
Varicose Veins – Overall range 44.4% to 66.7% (Calderdale and Huddersfield NHS Foundation Trust – 53.4%, England 53.9%)

"The staff were wonderful. They couldn't have been a nicer group of people. They were lovely"

Mum after her baby was rushed into Calderdale Royal Hospital with suspected meningitis

Review of quality performance – how we compare with others

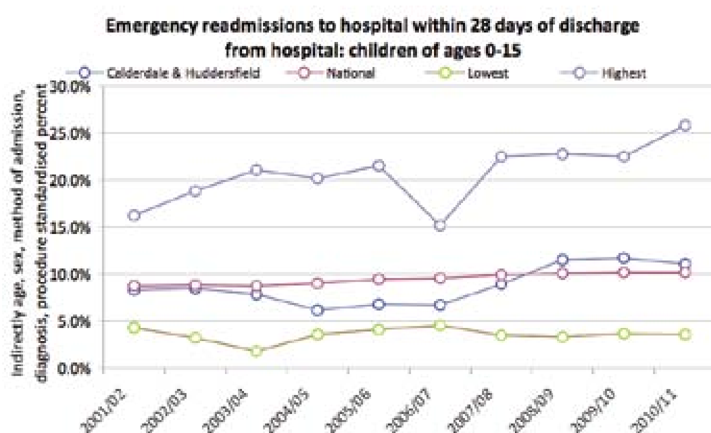
The reported health gains for Groin Hernia and Varicose Veins are lower than for Hip and Knee replacements; this could be due to patients not actually experiencing problems such as pain or reduced mobility prior to the procedure.

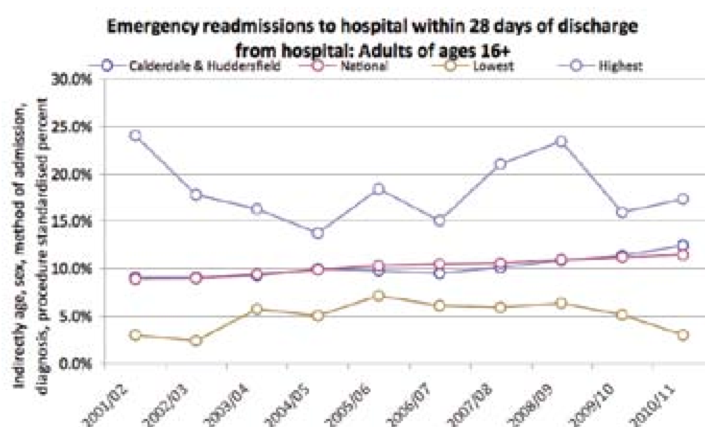
The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

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

19. Readmissions

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





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

- During the period shown the Trust has been through some significant reconfiguration affecting the way in which we deliver services. The way in which we record a visit to hospital can also have an impact on these figures.

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

- In December 2010 the Trust introduced a team to support patients at risk of readmission after they are discharged from hospital, helping ensure that patients understand how to manage their condition. This service has been very positively received by patients improving their experience of care. We are also reviewing and improving our discharge processes and developing services to deliver care in people's homes and in community settings.

The external auditors tested the validity of our readmissions data on 2012/13 patients, for which the readmission rate was 11.3%.

20. Responsiveness to the personal needs of patients.

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

This indicator forms NHS Outcome Framework (Domain 4 - Indicator 4.2) and the latest data is available on the Health and Social Care Information Centre Portal for 2003/04 to 2011/12 national inpatient surveys results at: https://indicators.ic.nhs.uk/webview/ Indicator P01391.

The charts show the Trust's responsiveness to the personal needs of patients during the reporting period.

Viewing your 2012 CQUIN scores from CQC survey data available locally in February 2013

Your overall 2012 CQUIN score

Select your Trust: **Calderdale and Huddersfield NHS Foundation Trust**

2012 Trust CQUIN Score: 69.7

The Trust score at the end of 2012/13 to be used for payments from the 2012/13 scheme

	2003	2005	2006	2007	2008	2009	2010	2011	2012
Your scores	70.7	70.5	68.3	66.0	66.0	66.0	65.9	66.8	**69.7**
SHA cluster	67.9	68.3	66.8	65.9	67.2	67.5	68.3	68.6	69.1
National	67.4	68.3	67.0	66.0	67.1	66.7	67.3	67.4	

2012 national scores are not presented. Early access to 2012 data for the 5 CQUIN questions (i.e. pre publication of the Adult Inpatient 2012 survey) is specifically for the purposes of CQUIN. Thus restrictions apply on sharing data.

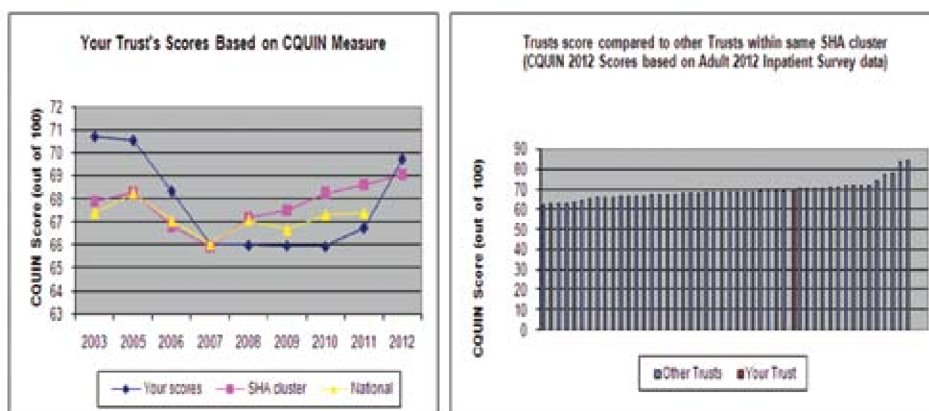
Your scores on individual questions, and on the overall indicator

	2012 Score:
Q32: *Were you as involved as you wanted to be in decisions about your care and treatment?*	73.5
Q34: *Did you find someone on the hospital staff to talk to about worries and fears?*	60.5
Q36: *Were you given enough privacy when discussing your condition or treatment?*	83.9
Q56: *Did a member of staff tell you about medication side effects to watch for when you went*	50.8
Q62: *Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*	79.9

OVERALL INDICATOR 2012 score out of 100: 69.7

The process of setting thresholds last year took account of sampling variation in the data, so in assessing last year's performance you should simply compare the number above with the thresholds agreed locally. There is no need to allow for sampling variation again.

Viewing your 2012 CQUIN scores from CQC survey data available locally in February 2013



This data should enable you to assess whether you have reached your 2012 CQUIN patient experience threshold. They are unlikely to change in the final publication in Spring 2013.

Review of quality performance – how we compare with others

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

- This value has increased from a composite score of 66.8 in 2011/12 to a composite score of 69.7 in 2012/13. This was an over achievement of the target of 67.1, set as part of the National CQUIN scheme

The data relates to a composite score of the following 5 questions:
Q32: Were you as involved as you wanted to be in decisions about your care and treatment?

Q34: Did you find someone on the hospital staff to talk to about worries and fears?

Q36: Were you given enough privacy when discussing your condition or treatment?

Q56: Did a member of staff tell you about medication side effects to watch for when you went home?

Q62: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

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

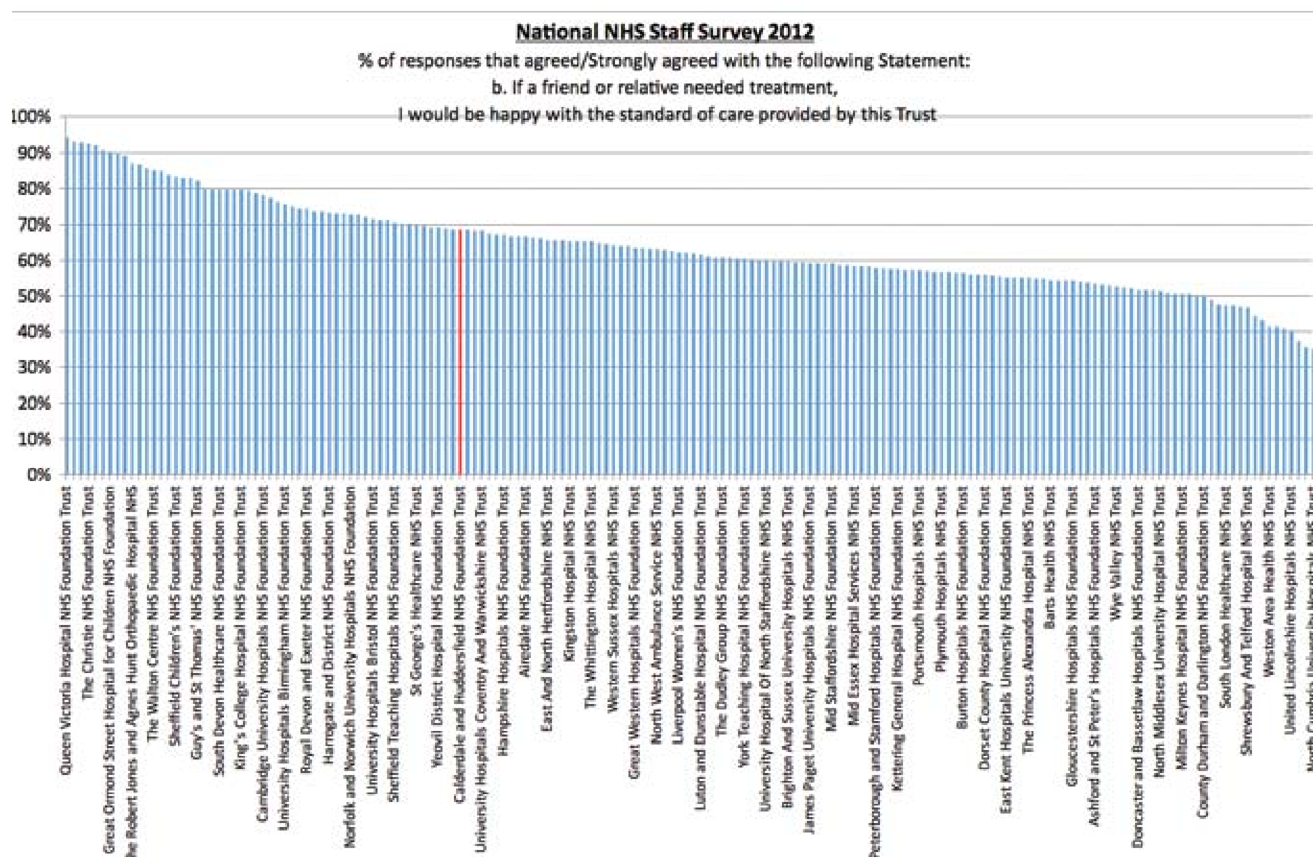
- Continued monitoring of individual ward-based scores on a quarterly basis by ward sisters and matrons as part of the real time patient monitoring reports.
- Increased presence of ward-based pharmacists.
- Use of a discharge proforma – includes prompt on who to contact if worried about condition after discharge.
- Communication campaign to raise the importance of providing timely discharge information.
- Establishing a discharge collaborative.

"Staff always listened to anything I had any concerns about even though I was only an inpatient for 24 hours"

"The overall quality of the nursing care was very high, with, on occasion, special efforts made to meet my needs"

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

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



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

- The Trust's staff survey is based on a sample of 850 staff. The response rate was 60% - making a total of 505 staff who participated in the survey. The sample was drawn from a total of 5,722 eligible staff employed at the time of the survey (September 2012).

  The staff survey score for KF24 - Staff recommendation of the Trust as a place to work or receive treatment is 3.70 out of 5. The score in the 2011 survey was 3.57 out of 5. This is a summary scale score calculated from the scores of the following questions:

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

Our sample frequency scores indicate that:

1, 65% agree that care of patients/service users is the Trust's top priority
2, 59% would recommend their Trust to others as a place to work
3, 69% would be happy with the standard of care provided by the Trust if a friend or relative needed treatment

Review of quality performance – how we compare with others

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

- The Trust continues to build our exemplar programme to ensure patients are put at the centre of care. The Trust is developing work on patient experience to truly understand the care provided and to ensure colleagues feel empowered to deliver the care they would expect themselves

- The Trust is currently refreshing its approach to staff engagement and is developing a strategy to build our future under the heading of 'Having the courage to put the patient first'. The strategy will be informed by external assessment conducted against the Investors in People Core Standard. The Trust has recently been advised of its success in retaining its Investors in People recognition. The Trust is one of only a few NHS organisations in the country to achieve and maintain this status over a sustained period, in the Trust's case for more than 10 years. The strategy will build on the Trust's four strategic themes of keeping the base safe; strategic alliances; internal reconfiguration and staff utilisation; and integrating our services with primary and social care.

  The key elements of the strategy will include delivering excellent leadership and management, enabling staff to be involved in decision-making, promoting a healthy and safe work environment, ensuring every role counts and supporting personal development and training. Using these five elements, the Trust will design a comprehensive and integrated approach to the whole of the employment relationship – from entry point screening through to exit interviews when colleagues leave to provide feedback upon which the main elements of the engagement strategy can be tested.

- The Trust is implementing the Friends and Family Test in order to understand what patients say about the care provided. The Trust undertakes the transparency project to ascertain the patients and staff experience in real time; this provides us with an opportunity to intervene and perform improvements to focus on both patient and staff satisfaction.

Staff survey

The Trust's staff survey this year showed improvements across many areas.

The survey, which was published at the end of February 2013, highlighted that staff feel able to contribute towards improvements at work and would recommend the Trust as place to work or receive treatment.

We had an excellent response to the survey of 60 per cent and were in the top 20 per cent nationally.

It's a remarkable achievement that staff report improvements in so many areas, amid all the pressures and uncertainties around at the moment.

The Director of Personnel and Development, Julie Hull thanked staff wholeheartedly for taking part in the survey.

On the negative side the survey showed staff experience had fallen with regard to the reporting of errors, near misses or incidents witnessed. Experience had also declined in the availability of hand washing materials. These figures were, however, still above the national average.

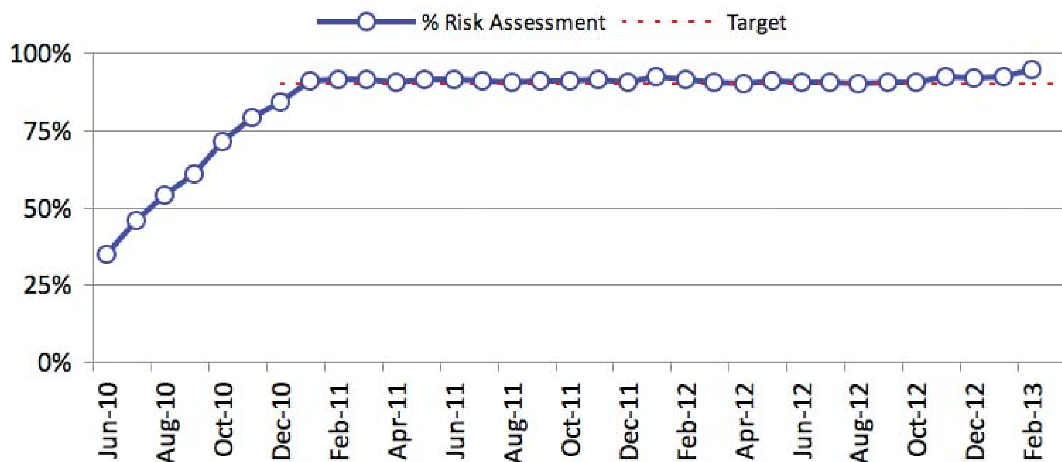
Work to address the concerns of staff within the survey will form part of the staff engagement strategy. Staff will be given the chance to be involved in this.

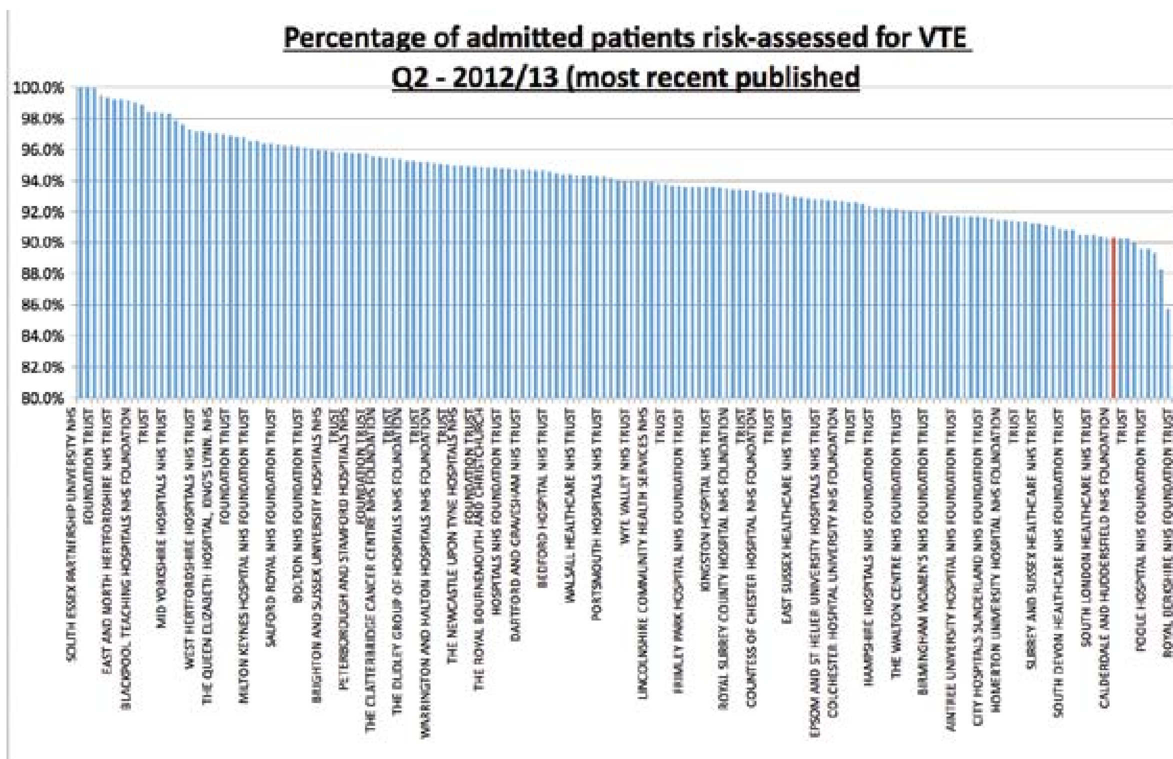
As a Trust it is very important for us to find out what our staff think about working here and how we can improve conditions for them. We are pleased with this year's above average results in key areas yet we recognise improvements are needed in some areas.

Review of quality performance – how we compare with others

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

The charts show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from June 2010 to February 2013.





Review of quality performance – how we compare with others

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

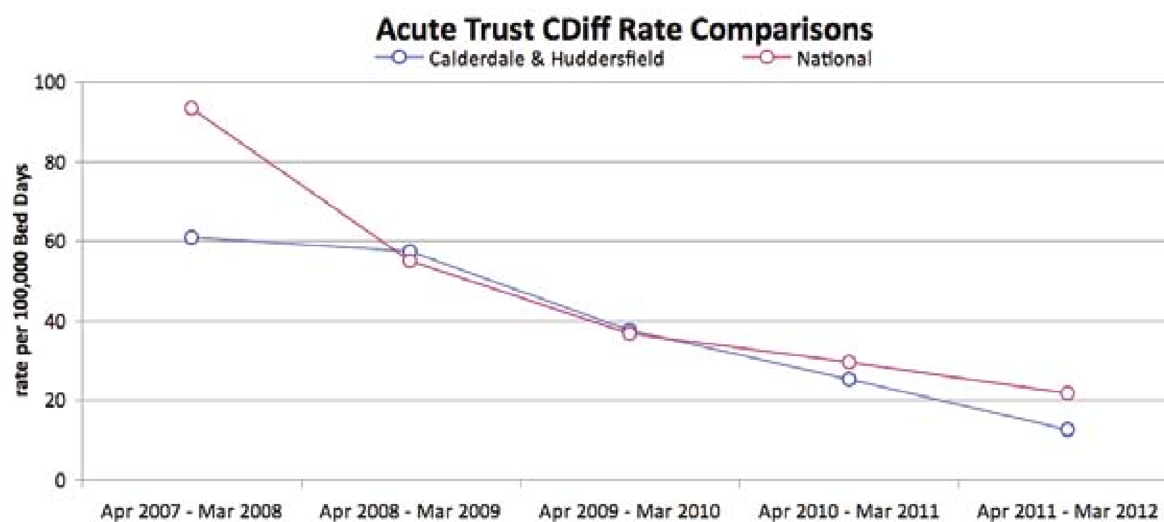
- From December 2010 the Trust has maintained an assessment on 90% of all patients admitted. The target from 1 January 2011 to 31 March 2013 has been 90%. The benchmarking graph shows the Trust to be in the bottom 10% of Trusts. From December 2012 the number of inpatients risk assessed for VTE has continued to rise and the February 2013 figure was 94.6% (this improvement is not shown on the chart).

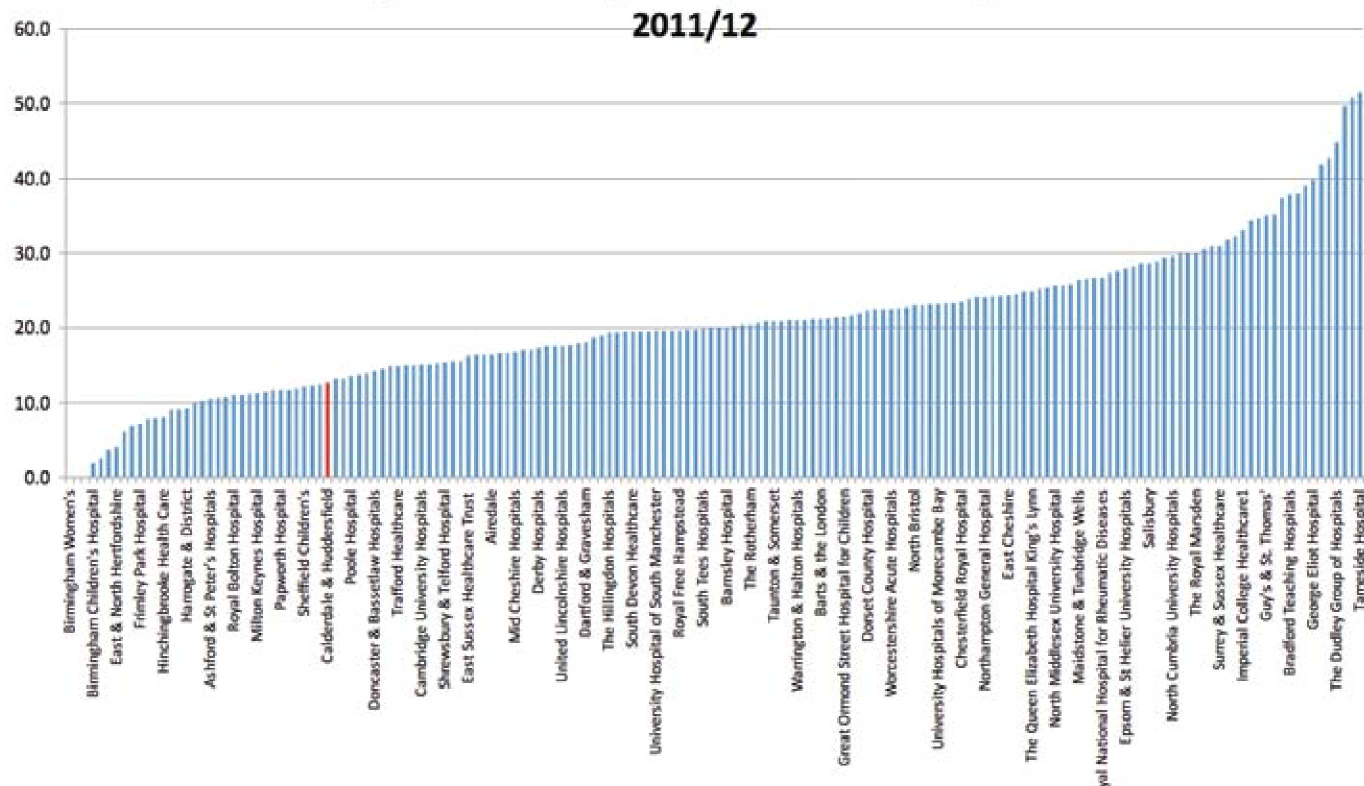
The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this and so the quality of its services, by:

- Aiming to reach a 95% minimum number of patients having a VTE risk assessment carried out in their admission (in line with local and national targets). To maintain our level of correct prophylaxis being given following risk assessment at 99+%. Quality improvement nurses continue in their key role of educating doctors to complete the risk assessment. Ongoing improvements are being made through studying all hospital acquired VTEs, learning from any gaps in compliance and therefore by addressing these so the Trust can increase the quality of care provided.

24. Rate of C.difficile infection.

The charts shows the rate per 100,000 bed days of cases of C-difficile infection reported within the Trust amongst patients aged two or over during the reporting period from March 2008 to March 2012.





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

- All cases of Clostridium difficile infection and MRSA bacteraemias in 2012/13 have been reported externally using the Health Protection data capture system and internally to the Executive Board and Board of Directors monthly.
- The charts show that the Trust has improved on rates of C-difficile infections over the last five years.
- The first chart shows that the Trust's performance has been better than the national average.
- The second chart shows that in 2011/12 the Trust performed very well when compared to other similar NHS organisations.

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

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

Review of quality performance – how we compare with others

Three years C-diff clear!
The teams on ward 4 at Huddersfield Royal infirmary have notched up an amazing 1,000 days without a single case of C-difficile.

The achievement was notched up thanks to a combination of factors but mainly good working practice.

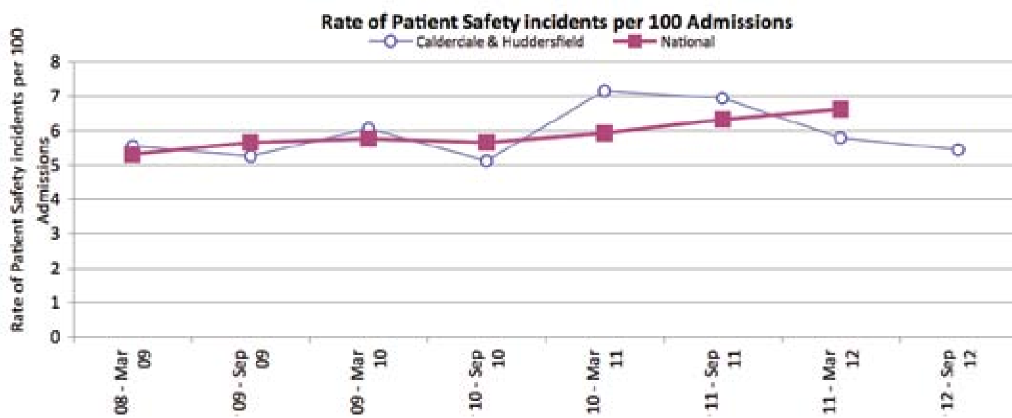
The doctors led by Gudrun Seebass are extremely on the ball with their antibiotics prescribing, keeping it limited and appropriate. Dr Seebass is very serious and passionate about getting it right and this is reflected throughout the medical teams. Ward 4 is a relatively compact area but they try not to use commodes and there is really good practice in evidence in all areas. The learning from ward 4 is being rolled out to all areas.

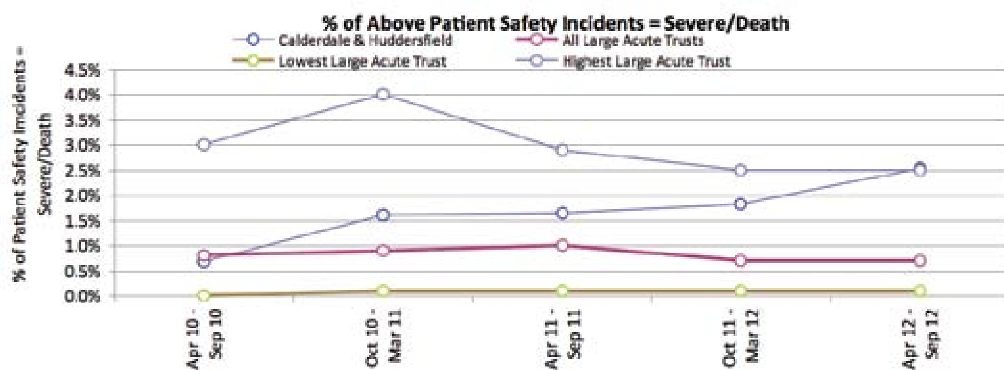
The Trust's record in infection prevention continues to improve in the face of increasingly challenging annual targets.

It is very much on-going work because we do not want even one of our patients to pick up what can be a very debilitating infection. Three years without is very impressive.

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

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





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

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

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

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

There have been 2 never events reported both from Children's, Women's and Family's Division, one in September 2012 and one in November 2012. Both events were retained swabs after a forceps birth in the labour room. These events have been subject to thorough investigations.

The common themes highlighted are:

- Primary operator in all cases was a specialist registrar in Obstetrics and Gynaecology.
- The incidents occurred in the labour room on Labour Delivery Recovery and Postnatal suite (LDRP) rather than Maternity theatres.
- There was a deviation from "counting" procedures in both cases.
- Record keeping was inadequate in both cases.
- Poor communication between staff groups in the unit (doctors, midwives and nurses).
- Workload on LDRP was noted to have been busy and could have contributed to swab/needle checks not being carried out correctly.
- Failure to follow policy for counts and checks

During the investigation process, risks were identified and an action plan written to address these.

Actions:
White boards in delivery rooms - process of getting white boards so the visual count process can be replicated to that which happens in theatres.

New types of swab are being ordered that have tape attached and are therefore easier to detect.

Along with this the never events have been discussed through the Division at mandatory training so key learning has been shared.

Weekly audits of minimum 10 records following suturing in LDRP and Calderdale and Huddersfield Birth Centres are taking place.

Action plans have been developed to address any poor documentation and are being addressed by the divisional managers and copied to the Director of Nursing.

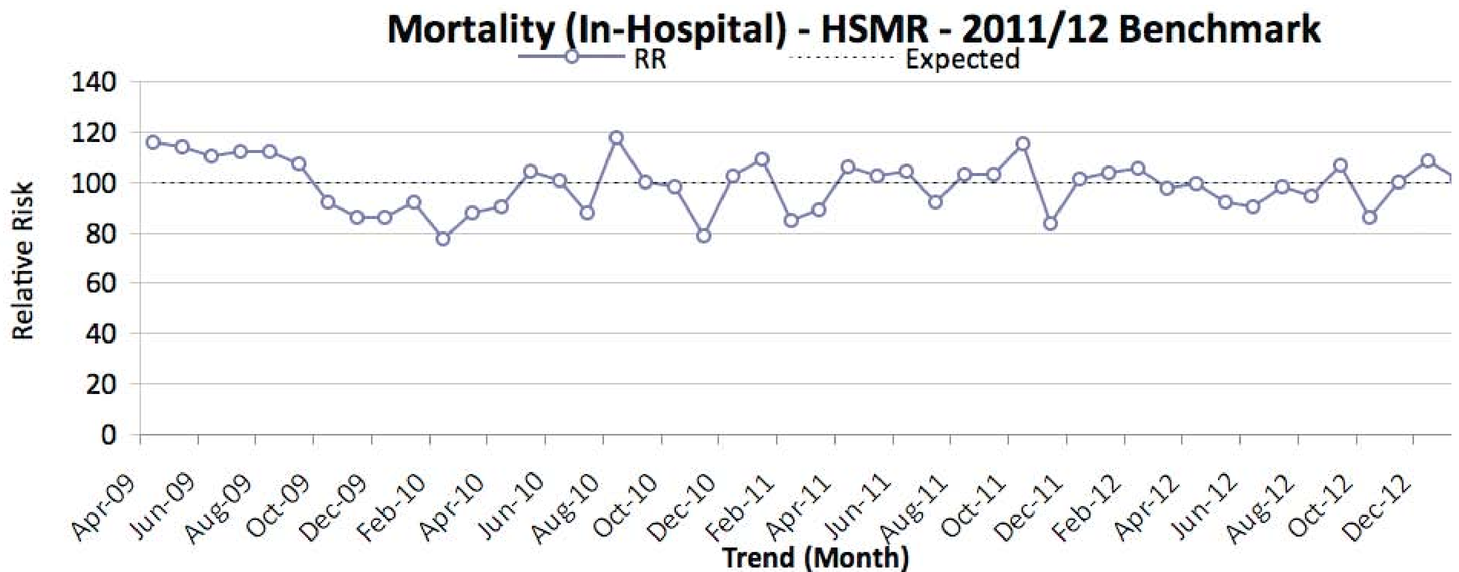
This section provides an overview of care offered by Calderdale and Huddersfield NHS Foundation Trust based on our performance in 2012/13 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason for selection.

The indicators are as follows:

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

Hospital Standardised Mortality Rate (HSMR)

HSMR is a national measure that we use to compare our death rate with that of other trusts.

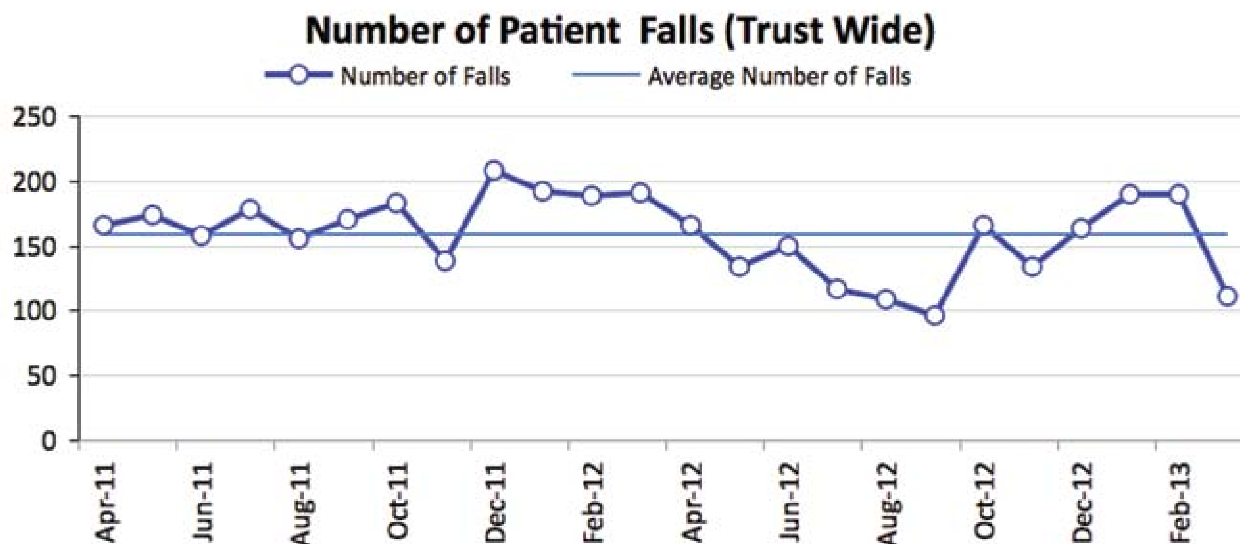


On the chart the dotted 100 line indicates the expected rate of overall deaths for the Trust (our relative risk), we aim to maintain our score below this line as this tells us we have a lower than expected rate for our population.

As well as an overall rate, HSMR is also available for certain clinical conditions and is closely monitored in the Trust. If any conditions alert we investigate thoroughly and instigate any necessary changes.

Falls in Hospital

Hospital falls continue to be the highest reported safety incident in the Trust and therefore remain a priority for improvement. The chart shows the number of falls our patients had whilst inpatients, on average this was 160 per month. New falls prevention equipment has been allocated to high risk wards including alarms and specialist beds. In addition work is ongoing on ensuring risk assessments continue to be completed and importantly that the appropriate actions are then taken.



Healthcare associated infections (HCAIs)

Part 2; Priority two, sets out the Trust's plans for reducing MRSA. In the 'look ahead section for 2013 /14' there is further information around the Trust's plans to reduce HCAIs.

"I was a patient at HRI in 2010 and they looked after me so well I wanted to do something for them as a way of a thank you"

Craftsman Bill Nixon who donated a rocking horse to the children's clinic

Cancer Waiting Times

Each year in England around 255,000 people are diagnosed with cancer and around 130,000 die from the disease. Currently about 1.8 million people are living with and beyond a cancer diagnosis.

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

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

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

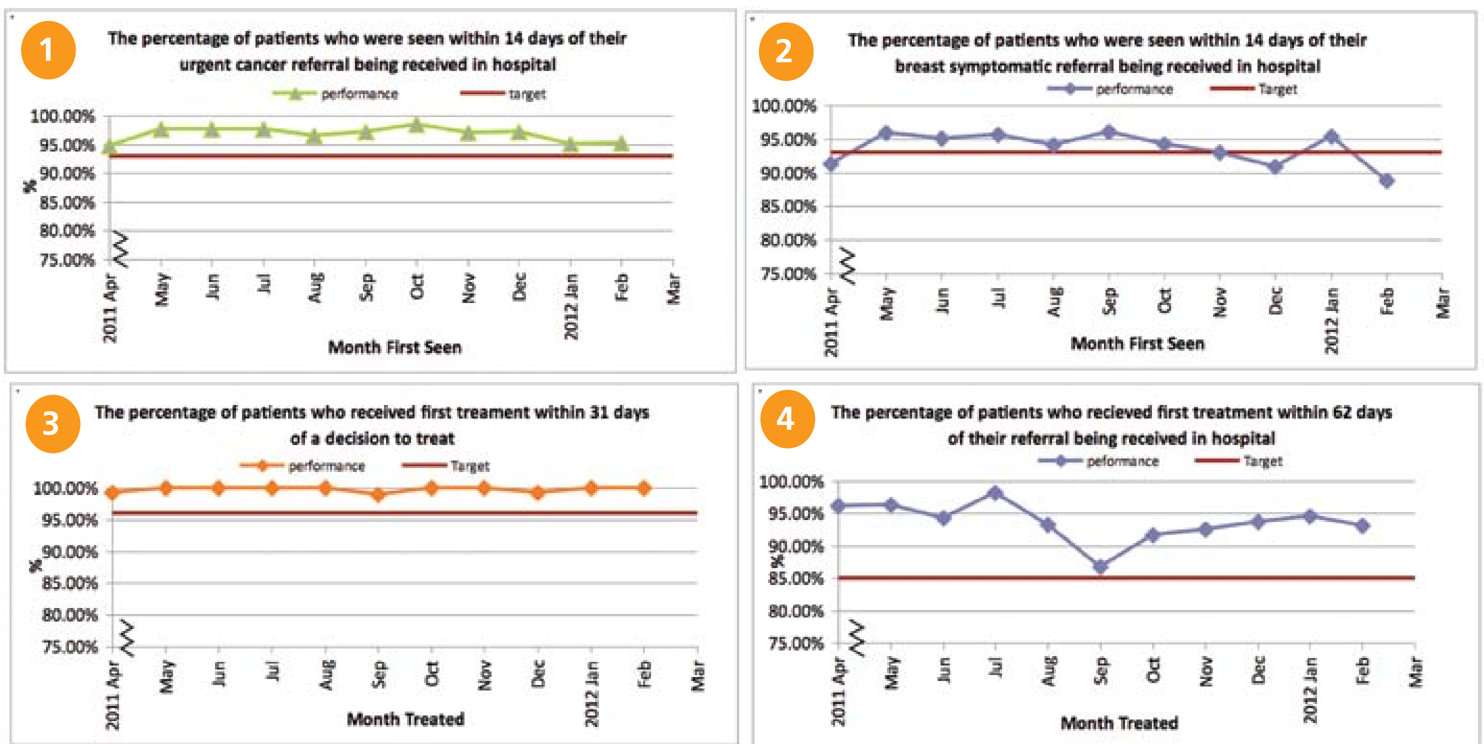


Chart 1 shows the Trusts reporting period April 2011 – March 2012 for patients seen within 14 days for urgent referral.

- The performance required for this target is 93% and this has been exceeded for the whole of the year.

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

- Patient choice of appointment date and time is a key driver for performance. The Trust continues to work with primary care colleagues to ensure patients are fully aware and informed of the need to attend within 14 days.

Chart 2 shows the percentage of patients who were seen within 14 days of their breast symptomatic referral being received in hospital

The chart shows the Trust's reporting period April 2011 – March 2012. The performance required for this target is 93%. Performance has been variable largely due to patients exercising choice about time and date of appointment.

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

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

Chart 3 shows the percentage of patients who received first treatment within 31 days of a decision to treat

The chart shows the Trust's reporting period April 2011 – March 2012. The performance required for this target is 96%. Performance has largely been maintained at 100% with slight variations on three occasions; however this has not fallen below the target. Due to the low numbers treated, this amounted to three breaches within the year and was due to the complexity of the patients' condition.

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

Chart 4 shows the percentage of patients who received first treatment within 62 days of their referral being received in hospital

The chart shows the Trust's reporting period April 2011 – March 2012. The performance required for this target is 85%. Performance has been above the required 85% for all of the year.

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

- Review of CT scan availability.
- Working with primary care colleagues to review the diagnostic pathway.
- Continue to work with tertiary centres to improve handovers.
- Continue robust tracking of patients.
- Pilot the introduction of a dedicated resource looking to introduce further electronic solutions to support the patient pathway tracking.
- Project Group set up to introduce 2 week waits on to Choose and book.

Care for cancer survivors

Women in Calderdale are the first in Yorkshire to undergo a pioneering new form of post-cancer treatment.

Instead of hospital appointments, the new approach involves a 10-week course of information and social sessions and free gym membership to promote healthy lifestyles in a unique partnership link with Calderdale Council.

This new approach – the first in the Yorkshire Cancer Network area – is called Upbeat Cancer Rehabilitation and is being trialled by women who have undergone treatment for low-risk cancer of the womb.

Consultant gynaecologist Mr Cheng Choi and specialist oncology gynaecology nurse Pat Marsden have introduced the new care for patients in Calderdale and Huddersfield and the sessions are held at Calderdale Royal Hospital.

It is a new approach and it could well be the future for cancer treatment in a whole range of conditions. It is less-hospital based for low-risk women which reduces anxieties and focusses on the social, positive and healthy side of life after cancer.

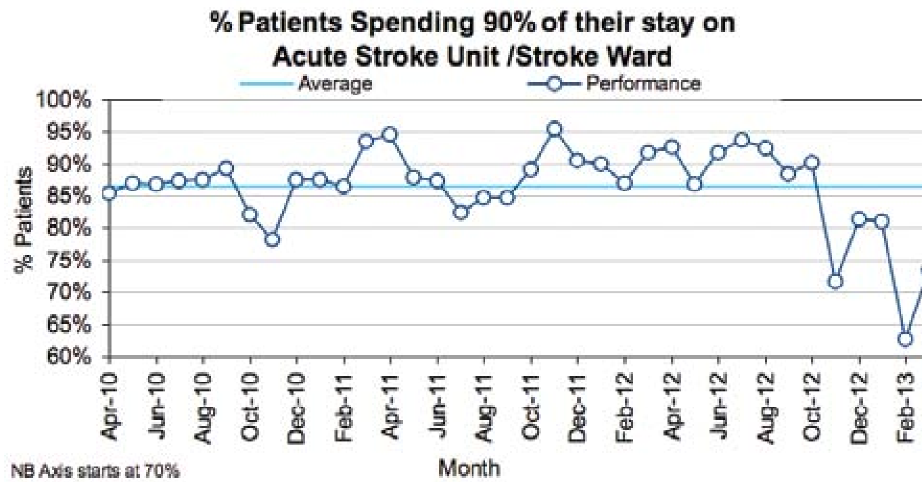
The information sessions involve chats about healthy eating and participants can design their own exercise element to the sessions which can range from zumba to less strenuous exercise such as tai chi or yoga. They can also attend gym sessions run by Calderdale Council for just £2.50 a session during the 10 weeks.

Patient Sheena Gilhooley, from Lee Mount, Halifax, said: "I think the whole thing is brilliant. People sometimes think they have been forgotten about after surviving cancer. Being here makes me feel a lot better."

Julie Scott, from Calderdale Council, said: "A healthy lifestyle, which includes eating healthily and more exercise, can improve everyone's long-term health outlook. And, for these ladies, the extra support from other patients on top of that from their families can make such a difference to their confidence and outlook."

Stroke

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

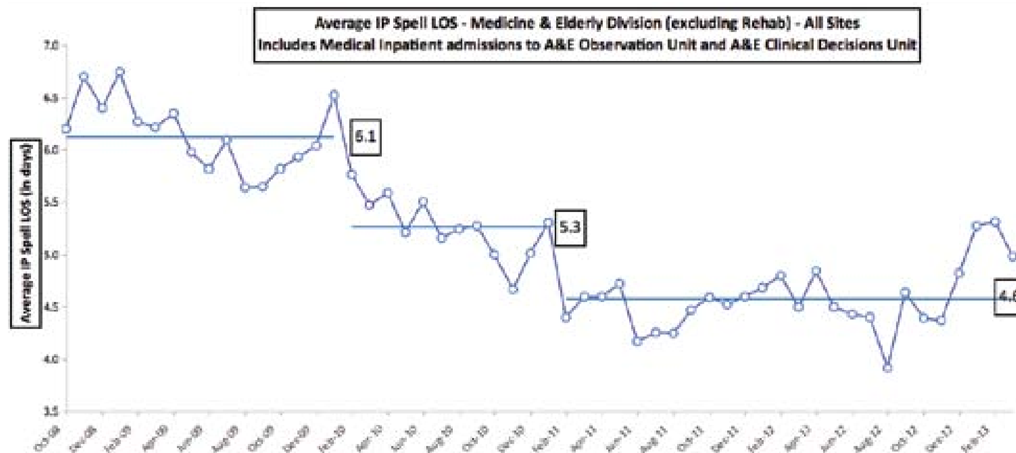


The above chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward. The average for the period was 86%. Throughout 2012 the Trust has maintained high performance ensuring patients are cared for on the specialist stroke wards. Performance did drop early this year due to winter pressures when the hospital was unusually busy with extra beds opened. During this time the Trust could not get the stroke patients admitted directly to the ward.

Following a peer review of the Trust's stroke service, it has been accredited for its operational standards.

Length of stay in medicine

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



In 2012 the Trust had the fourth lowest overall average length of stay when compared with 44 large acute trusts using Dr Foster ratings. Dr Foster provide comparative information on health and social care services in the UK.

The continued roll out of 'plan for every patient' this year has made inroads into ensuring care is planned and delivered in as timely a way as possible, this is ongoing work and the Trust hopes to continue to drive down the length of stay whilst still maintaining the delivery of good quality care. Unfortunately the Trust has seen an increase in length of stay over the winter period, some of which is seasonal. The Trust is currently investigating other reasons for the increase.

Real time patient monitoring

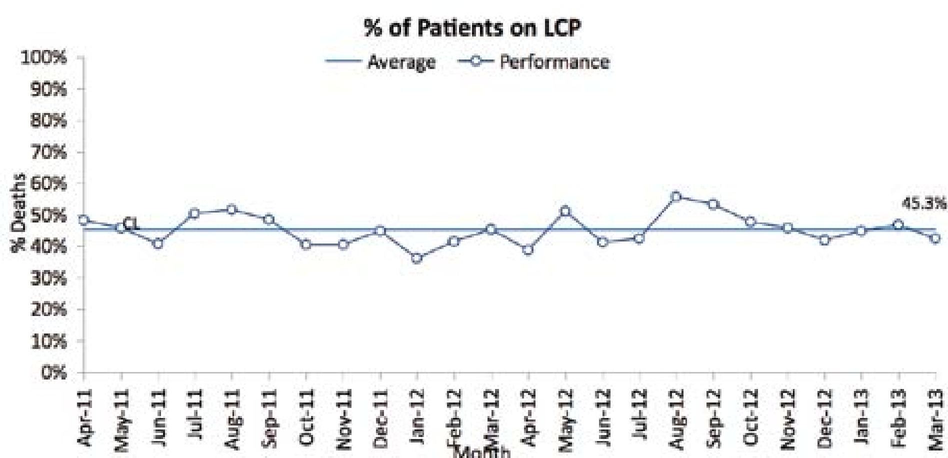
The Trust continues to operate a real time patent monitoring system. Using volunteers to ask patients a set of pre determined questions when they are ready for discharge allows the Trust to relate feedback to specific wards and therefore drive improvement. One example is that asking patients questions around doctors' communications has led to the following improvements:

- Development of divisional and specialty champions for the 'Delivering Excellent Communication Skills' programme
- 'Dear doctor' notes where patients are encouraged to capture questions prior to ward rounds to ensure they have all their queries answered
- 'PLEASE' poster in all clinical areas reminding doctors of the importance of good communication

Further details around other uses for this information is contained in Part 2; Priority five: Improving doctors' communication with patients, and Priority six: Improving patient information on discharge

End of life care

The Trust continues to work to ensure that when patients die in hospital their death is expected and they are on the end of life care pathway.



"The doctors are very passionate and serious about getting it right and this is reflected throughout the medical teams"

Infection control and Prevention nurse Jean Robinson, after a ward goes three years without a C-diff

The graph shows the percentage of patients dying who were placed on the end of life pathway. Of those patients who died in hospital an average of 46% were on the pathway.

A training lead for end of life care is now in place for the Trust ensuring staff understand all the issues and monitoring performance against standards.

Plans are in place to move across to the Liverpool Care Pathway, this is in line with other acute trusts and will enable the Trust to benchmark performance and target any improvement where needed.

Patient experience in Accident & Emergency

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

A&E RTM Comparison of Quarterly Results after Offset

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

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

A&E Activity in 2012/13 and for 2013/14.

Questionnaires were collected and reported quarterly in 2012/13, but numbers fell off badly in the last 2 quarters due to departmental pressures. The National Picker survey was reported at the end of 2012, and was reported to Executive Board in February 2013. Concerns with sustainability and support were discussed.

Patient experience questionnaires restarted from April 2013 with the first submission due at the end of June 2013. Questionnaires have been altered slightly to include up-to-date questions and issues. Volunteers are being trialled in the departments to support data collection.

Learning from Complaints and Concerns

The key themes that have emerged from analysis of the complaints and concerns received through the 2012/13 period are as follows:

- Hospital discharge issues – these are mainly around delays when patients are kept waiting for medications and equipment and issues with planning of the discharge. Also some concerns were from relatives and carers when patients were discharged and their perception was they were not well enough to leave hospital.
- Administration of Clinics – these often relate to delays in appointments and last minute cancellations.
- Expressions of concern around the standard of care provided - these include delays to treatments, waiting for test results and general communication issues with the clinical teams.

A common theme that runs through complaints is around communication. One often cited issue is that patients and carers are not getting the information they need and are unsure of the plans of care.

This is all valuable information and helps with the planning of changes and improvement to the care the Trust provides. Discharge is of concern and as such there is a Discharge Improvement Collaborative in place. It was also one of our priorities for last year and has again been selected moving forward for 2013/14. Cancelled clinic appointments and non attendees cause issues for the patients and also results in wasted resource for the Trust. Plans are in place to introduce a partial booking system so routine follow up appointments will be finalised closer to the date, reducing the risk of non attending and also allowing patients more choice and convenience. In addition the Trust is introducing a new voice messaging service and two-way text to act as a prompt.

All improvement work being carried out with clinical teams has as a central theme good communication, which encompasses the Trust's aim to always put the patient first. One arm of the quality improvement strategy is improving patient experience, using information gleaned from tools such as real time monitoring and complaints and concerns we can understand where we fall short of providing good experience to patients and plan work to improve this.

Performance against key national priorities

Area	Indicator	Threshold	Performance April 2012 to Feb 2013	Achieved
Safety	Clostridium Difficile – meeting the Clostridium Difficile objective (2)	33	29	✔
Safety	MRSA – meeting the MRSA objective (3)	4	4	✔
Quality	All cancers: 31-day wait for second or subsequent treatment (4), comprising either: surgery anti cancer drug treatments radiotherapy	94% 98% 94%	99.4% 100%	✔ ✔
Quality	All cancers: 62-day wait for first treatment (5), comprising either: from urgent GP referral to treatment from NHS Cancer Screening Service referral	85% 90%	93.8% 96.7%	✔ ✔
Patient experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted (6)	90%	90.6%	✔
Patient experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted (6)	95%	99.1%	✔
Patient experience	Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway (6)	92%	92.2%	✔
Quality	All cancers: 31-day wait from diagnosis to first treatment (7)	96%	99.8%	✔
Quality	Cancer: two week wait from referral to date first seen (8), comprising either: all urgent referrals (cancer suspected) for symptomatic breast patients (cancer not initially suspected)	93% 93%	96.9% 93.8%	✔ ✔
Quality	A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge (9)	95%	95.3%	✔

Performance Monitoring

The following is some information on red rated performance indicators from the Trust's performance report with an explanation of actions taken to improve.

I. Fractured neck of femur 36 hours of admission: Over the past year the Trust has achieved 75% performance, however the target is 85%. To improve this the Trust is introducing enhanced recovery optimising patients prior to their surgery and therefore reducing their length of stay. The Trust is also funded to increase theatre sessions at the weekends. Fracture neck of femur patients are always prioritised to be first on the list to help ensure the procedure is not cancelled. The Trust has also lengthened theatre time by starting lists earlier in the day.

II. Delayed transfers bed days as a percentage of occupied bed days: The Trust is working to reduce delays in transfer of care by continuing to improve our internal processes and provide patients with timely discharge planning. The Trust also continues to engage with local authority colleagues to work together to forge a collaborative approach to discharge.

III. Mixed sex accommodation breaches: These are rare events and every effort is made to ensure this standard is met. When this occurs the issue is escalated to the director on call to ensure the appropriate decision is made. As soon as the situation can be rectified patients are moved to single sex accommodation. The wards at the Trust's Huddersfield hospital are undergoing a programme of refurbishment which will increase the number of side rooms available and therefore reduce the risk of this occurring.

IV. Provider cancellation of elective inpatient operations for non-clinical reasons: There are many reasons for non-clinical cancellations of operations; one is linked to list overruns that have an effect on theatre space for following sessions. To redress this the Trust is improving list scheduling and theatres are starting earlier. The Trust is also working with the sterilisation provider to improve turnaround time for key equipment, where a continued shortage is highlighted extra equipment is ordered. Sometimes surgery is cancelled due to unavailability of key staff; the Trust works as flexibly as possible to always try to get cover for a list.

Patient survey results in relation to delayed appointments were also highlighted to the Trust as being of concern. Clinical divisions are looking at their capacity and demand plans to ensure enough appointments are available. In addition the appointments team is introducing a partial booking system where requests for future appointments are held on the system until nearer the time. Patients are then contacted and a convenient appointment is negotiated. This will cut down on the number of hospital cancellations due to changes in service provision and also patient cancellations as the times will be more convenient.

V. E-Coli: Although this is not an external target mandatory surveillance prompted a clinical review of a 3 months period of E Coli cases. Looking at the themes, one common association is with urinary catheters. This information has been fed into the Urinary Catheters collaborative to be incorporated into ongoing improvement.

VI. Screening all elective inpatients for MRSA: The target for this is locally set at 100%. The Trusts average performance for the past year has improved and is now at 96%.

VII. Did not attend – follow up appointments: To reduce the number of these the Trust is in the process of introducing a new voice messaging service and two-way texts to act as a prompt.

VIII. Sufficiency of appointment slots on choose and book: Improvements around this are linked to divisional capacity plans, at present there are not sufficient slots to meet demand via choose and book. Projections are being worked on to ensure this issue is addressed moving forward.

Performance against key national priorities

One of the Trust's stakeholders asked how the Trust specifies its nurse staffing levels:

Nurse Staffing Levels
Key to delivering safe, effective care is ensuring the right staffing levels and skill mix for the patient group. There is no universal or simple solution to nurse staffing issues.

The Trust utilises a number of methods and, often, more than one methodology is used to triangulate information and data to strategically plan the workforce and to ensure service needs are met on a day to day basis.

The methods used in the Trust are:

- The Association of UK University Hospitals Dependency Tool (AUKUH).
- Northwick Park Rehabilitation Tool.
- Royal College of Nursing (RCN) Safe Staffing for older people's wards.
- Professional judgements.

The AUKUH is used to measure acuity and for dependency of patients. It provides an evidence base to support existing services or help when planning the development of new services. Measurement takes place a minimum of twice a year to take account of changing demographics and healthcare needs across seasons. The tool allows professionals to accurately predict the resources needed to support nursing establishments.

The Northwick Park tool is utilised in much the same way as the AUKUH tool; however, it focuses more on dependency than acuity and is, therefore, utilised on rehabilitation wards.

The Trust also adheres to the recommendations made by the Royal College of Nursing (RCN) regarding nurse staffing on the wards where older people are cared for. This takes into consideration that older people often have highly complex needs which require skilled care and enough time to meet their needs in a dignified way.

Senior nurses within the Trust also use their knowledge and experience to make a professional judgement regarding both the skill mix (the ratio of qualified nurses and support workers to the number of patients on the ward) and establishments (the actual number of nurses and support workers required to deliver high quality care).

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Groups

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 Greater Huddersfield CCG and Calderdale CCG.

The published account provides an assessment of quality levels in 2012/13 and clearly highlights CHFT's priorities for quality improvement for 2013/14.

The pledge to ensure that quality is a top priority along with a realignment of priorities to the NHS Outcome Framework shows the Trust's commitment to improving quality of services for patients.

The Quality Account describes welcome progress in many areas shown with fair comparisons drawn against other hospitals. We recognise the improvements made in a number of areas such as reducing the number of pressure ulcers by just over one third from the previous year and achieving all the elements of the dementia CQUIN.

The key Health Care Associated Infections (HCAI) priorities identified for 2012/13 have been addressed, and include strengthening the assurance framework and governance processes by re-establishing the Infection Control Operational Board. We welcome the invitation to Health Protection agency and the North of England HCAI lead to provide support and challenge through this improvement journey.

As commissioners we recognise the achievement on Ward 4 to be C-diff clear for three years and are keen that this good practice and lessons learned are rolled out across the Trust as a whole.

We are pleased to see commitment to the IT modernisation programme particularly if this will deliver electronic patient records. We do have concerns regarding the length of time for this programme to be completed. We expect the modernisation of IT services to be helpful in improving the quality of services and patient experience particularly around the interface of primary and secondary care.

The commissioners are pleased to note the focus on long term conditions and self management and are pleased that this approach is being rolled out to other conditions including asthma and diabetes.

We also note that in some areas, whilst there have been improvements there have been a number of areas of concern around quality in 2012/13. We expected more detail in the report of numbers of serious incidents with evidence of how the learning is embedded in practice. CHFT have noted that there are a higher number of serious incidents than other trusts. Further work is required to fully understand this and benchmarking may assist with this

As commissioners we are pleased to note that the CQC inpatient survey showed the Trust performance as above the SHA average. 2013/14 shows an ongoing commitment to learn from patient feedback and experience and we look forward to seeing improvements in the 2013/14 outpatient satisfaction survey as a result of the learning. We would be keen for the Trust to consider mechanisms for feedback to GPs on services in order for the relationship with primary care to be strengthened further.

We expect that 2013/14 provides an opportunity for primary and secondary care to work together to improve the patient journey by focussing on discharge correspondence, referral processes and outpatient appointments.

Following last year's quality account and our commissioning comments, we welcome the inclusion of a more detailed account of the 2012/13 CQUIN scheme and a full breakdown of CHFT's participation and non-participation in national audits and confidential enquiries.

There are a number of Quality areas we would have expected to see published in the Quality Account; Never Events reported during 2012/13; summary of any Care Quality Commission Inspections during 2012/13; how the Health and Social Care Strategic review will contribute to improving; quality and finally the positive news in relation to the accreditation of stroke services.

We are looking forward to working with CHFT for the year 2013/14 in order to achieve their improvement priorities.

Response from Healthwatch Kirkees

No response received, information was sent on 15th April and again on the 17th May 2013.

Response from Healthwatch Calderdale

Thank you for giving Healthwatch Calderdale an opportunity to comment on Calderdale and Huddersfield NHS Foundation Trust's Quality Account statement for 2012/13. As you are probably

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

aware Healthwatch is a new entity. Although we have recruited a Programme Board, they have not yet held a meeting and as such we are unfortunately unable to comment on the Quality Accounts.

Response from Kirklees Overview and Scrutiny Committee

The Well-being and Communities Scrutiny Panel, as the local health overview and scrutiny committee, has considered the Draft Quality Account and made an assessment against the Department of Health's suggested areas of comment:

- Do the priorities match those of the public?
- Have any major issues been omitted?
- Has it been demonstrated that patients and the public have been involved in the production of the QA?
- Any comment on issues the OSC is involved in locally.

The Panel is supportive of dementia being identified as a priority for 2013/14. This is a local priority, and the Panel suggests that consideration may wish to be given to going beyond the CQUIN target of undertaking a FAIR assessment of those who are 65 years old and above, and consider a lower age.

The priority of 'helping people to manage their long-term conditions' makes particular reference to the work being carried out on COPD. The Panel feels that that there are additional local priorities in respect of long term conditions, as detailed in the Joint Health and Well-Being Strategy – namely: cardiovascular, diabetes, pain and musculo-skeletal, and obesity.

The Panel has noted that there is minimal information on the current Calderdale and Huddersfield Health & Social Care Strategic Review, which has the potential to have a significant impact on health services within this area over the next 12 months.

The Panel did not have sight of any Quarter 4 data when considering the Quality Account, and was not therefore in a position to comment on this.

Response from Calderdale Overview and Scrutiny Committee

Thank you for giving the Scrutiny Panel the opportunity to comment on your Quality Account. I responded in February to your request for comments on your priorities and I am pleased to see my comments reflected in your draft Quality Account.

You report on your achievements against the seven priorities set for 2012/13. There are pleasing results for: the reduction in the number of patients with pressure sores; reduction in the incidence of MRDA bacteraemias; improving doctors' communication; and improving patient information on discharge.

It is also good to see a reduction in hospital readmissions, although, as you point out, you did not meet your target. Reducing readmissions to hospital is an area that the NHS and the local authority do work together on and should continue to do so. By managing the boundary between hospital and community, there are benefits not just for both organisations, but – much more importantly – for service users and patients as well. I hope that one of the outcomes of the Strategic Review will be to recommend further improvements in these areas.

As you know, the Scrutiny Panel completed a detailed piece of work on dementia a year ago, so I was delighted to see the progress that has been made in this area. The Scrutiny Panel has moved on to other areas of work now, but retains a close interest in services to people with dementia. One of the key findings of our review was that people with dementia spend significantly longer in acute hospital than other people. Addressing the number of people in acute hospital with dementia and their lengths of stay is crucial to the financial viability of the NHS. Again, I would expect the care stream of the Strategic Review focussing on long term conditions to make some important and far reaching recommendations in this area.

Ian R Hughes LLB Hons,
Solicitor Head of Democratic and Partnership Services

Response from Membership Council

On behalf of the Membership Council I confirm that no additions or amendments are required, and that the Membership Council endorses the Quality Account for 2012/13 and the priorities for 2013/14 – Janette Roberts, Deputy Chair of the Membership Council.

Calderdale and Huddersfield NHS Foundation Trust Response to Stakeholder Feedback

Calderdale and Huddersfield NHS Foundation Trust welcomes the response from stakeholders regarding the Quality Account. In response to specific issues raised we note:

1. We will include more detail in the report of serious incidents in future Quality Accounts. We will explore this further with

commissioners in the Clinical Quality Board held jointly with commissioners.

2. The Care Quality Commission inspections 2012/13 are referenced in the report Care Quality Commission registration section in Part 2.

3. The health and social care economy in Calderdale and Greater Huddersfield is working on a programme of transformation.

Both commissioning and provider services are working to address the significant challenges facing the health and social care sectors to ensure that people continue to receive high quality services, both now and in the future.

The 'Right Care, Right Time, Right Place' programme has seven partners. Joining the Calderdale and Huddersfield NHS Foundation Trust in this programme are: Calderdale Council; Calderdale Clinical Commissioning Group; Kirklees Council; Greater Huddersfield Clinical Commissioning Group; Locala Community Partnerships; and South West Yorkshire Partnership NHS Foundation Trust. The programme is being led by the two Clinical Commissioning Groups.

The aim of the programme is to improve the health, well-being and safety of local communities by supporting people to be independent and delivering the right care, in the right place at the right time. The intention is to do this by changing the way health and social care services are provided so that:

- People can easily access the right information and guidance so that they can make informed choices for them and their family;
- They are able to tell their story once and are then supported to make positive choices to manage their health;
- Wherever possible quality personalised care will be delivered close to home to help patients stay as safe, well and as healthy as possible, for as long as possible;
- Every child will have a healthy start and continue to lead a safe, happy life with every opportunity to achieve their potential within their families and communities;
- High quality, safe, specialist care will be available when it is needed;
- Care will be delivered in partnership with people, enabling people to manage and control their condition, build resilience and independence to reduce their reliance on medical intervention where possible;
- Information will be shared where that is in the best interests of individuals and their families so that the relevant information is available to health and care professionals;
- Where possible care will be provided at home, or close to home, with reduced reliance on hospital-based services;
- The use of information and technology to enable integrated working, care at home and independence is maximised;
- There is open working and partnerships with shared ambitions to improve efficiency and the quality of care; and
- The available resources are used in the best possible way.

4. The Trust has received accreditation for the provision of stroke services in 2012/13.

5. The Trust recognises there are many more areas of long term conditions than COPD. The Trust has addressed this through CQUINS agreed with commissioners for 2013/14 for asthma and diabetes, and the further development of the dementia CQUIN. The Quality Account is limited in the number of priorities we can identify; however, we wish to assure stakeholders that all long term conditions are a priority for us.

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:

  o Board minutes and papers for the period

  o Papers relating to Quality reported to the Board over the period April 2012/May 2013

  o Feedback from the commissioners dated 13th May 2013

  o Feedback from governors dated 20th May 2013

  o Feedback from Healthwatch dated 13th May 2013

  o The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2013

  o The 2012 national patient survey

  o The 2012 national staff survey

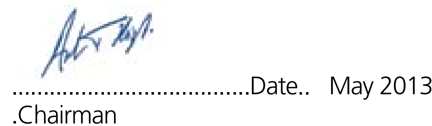
  o The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2013

  o CQC quality and risk profiles dated; April/June/July/August/October/November/December 2012 and February/March 2013

- 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



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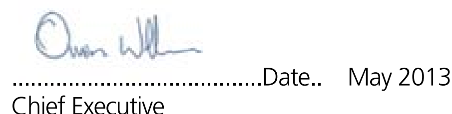

....Date.. May 2013
Chief Executive

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

Calderdale and Huddersfield NHS Foundation Trust

Appendix B: 2012/13 Limited Assurance Opinion on content of the Quality Report and mandated performance indicators

Independent Auditor's Report to the Board of Governors of Calderdale and Huddersfield NHS Foundation Trust on the Quality Report

We have been engaged by the Board of Governors of Calderdale and Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Number of Clostridium difficile infections; and
- Emergency readmissions within 28 days of discharge from hospital.

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

Respective responsibilities of the Directors and auditors

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

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

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

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

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with [either refer back to the specified documents in the guidance, or list those documents below:

- Board minutes for the period April 2012 to May 2013;
- Papers relating to Quality reported to the Board over the period April 2012 to May 2013;
- Feedback from the Commissioners dated 13/05/2013;
- Feedback from local Healthwatch organisations dated 13/05/2013;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17 May 2013;
- The latest national patient survey dated 2012;
- The latest national staff survey dated 2012;
- Care Quality Commission quality and risk profiles dated 31 March 2013;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated April 2013;
- Feedback from Overview and Scrutiny Committee dated May 2013; and
- Feedback from Governors dated 17 May 2013.

Calderdale and Huddersfield NHS Foundation Trust
Appendix B: 2012/13 Limited Assurance Opinion on content of the Quality Report and mandated performance indicators

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting Calderdale and Huddersfield NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Calderdale and Huddersfield NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

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

Calderdale and Huddersfield NHS Foundation Trust

Appendix B: 2012/13 Limited Assurance Opinion on content of the Quality Report and mandated performance indicators

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2013:

- 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; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual*.

KPMG LLP, Statutory Auditor

Manchester

20 May 2013

Trust Response to Patient Safety Indicator

Due to the judgmental nature of this indicator it is difficult to be certain that all incidents are identified and reported and that all incidents are classified consistently within the organisation and nationally. One individual's view of what constitutes severe harm can differ from another's substantially. As a Trust we work very hard to ensure all our staff are aware of and comply with internal policies on incident reporting and standardisation in clinical judgements.

APPENDIX A: Participation in Clinical Audits

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust was eligible to participate in during 2012/13 are as follows:

Women's & Children's Health	
Audit title	CHFT Eligible for Involvement
Child health programme (CHR-UK)	No
Epilepsy 12 audit (Childhood Epilepsy)	Yes
Maternal, infant and newborn programme (MBRRACE-UK)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Paediatric fever (College of Emergency Medicine)	Yes
Paediatric intensive care (PICANet)	No
Paediatric pneumonia (British Thoracic Society)	Yes
Acute	
Audit title	CHFT Eligible for Involvement
Adult community acquired pneumonia (British Thoracic Society)	Yes
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes
Emergency use of oxygen (British Thoracic Society)	Yes
National Joint Registry (NJR)	Yes
Non-invasive ventilation - adults (British Thoracic Society)	Yes
Renal Colic (College of Emergency Medicine)	Yes
Severe trauma (Trauma Audit & Research Network, TARN)	Yes
Blood and transplant	
Audit title	CHFT Eligible for Involvement
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	No
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:	
a) O neg blood use (2010/11)	Yes
b) Medical use of blood (2011/12)	Yes
c) Bedside transfusion (2011/12)	Yes
d) Platelet use (2010/11)	Yes
Potential donor audit (NHS Blood & Transplant)	Yes
Cancer	
Audit title	CHFT Eligible for Involvement
Bowel cancer (NBOCAP)	Yes
Head and neck oncology (DAHNO)	No
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes

Heart	
Audit title	CHFT Eligible for Involvement
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes
Adult cardiac surgery audit (ACS)	No
Cardiac arrhythmia (HRM)	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No
Coronary angioplasty	Yes
Heart failure (HF)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes
Pulmonary hypertension (Pulmonary Hypertension Audit)	No
Long term conditions	
Audit title	CHFT Eligible for Involvement
Adult asthma (British Thoracic Society)	Yes
Bronchiectasis (British Thoracic Society)	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Inflammatory bowel disease (IBD)	Yes
National Review of Asthma Deaths (NRAD)	Yes
Pain database	Yes
Renal replacement therapy (Renal Registry)	No
Renal transplantation (NHSBT UK Transplant Registry)	No
Mental Health	
Audit title	CHFT Eligible for Involvement
National audit of psychological therapies (NAPT)	No
National Audit of Schizophrenia (NAS) Prescribing Observatory for Mental Health (POMH)	No
Older People	
Audit title	CHFT Eligible for Involvement
Carotid interventions audit (CIA)	Yes
Fractured neck of femur	Yes
Hip fracture database (NHFD)	Yes
National audit of dementia (NAD)	Yes
Parkinson's disease (National Parkinson's Audit)	Yes
Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13	 Yes Yes

Other	
Audit title	CHFT Eligible for Involvement
Elective surgery (National PROMs Programme)	Yes
National Confidential Enquiries	
Audit title	CHFT Eligible for Involvement
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths: Subarachnoid Haemorrhage Alcohol related liver Disease Bariatric Surgery Cardiac Arrest Procedures	 Yes Yes Yes Yes
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust participated in during 2012/13 are as follows:

Women's & Children's Health	
Audit title	CHFT Participation
Child health programme (CHR-UK)	NA
Epilepsy 12 audit (Childhood Epilepsy)	Yes
Maternal, infant and newborn programme (MBRRACE-UK)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Paediatric fever (College of Emergency Medicine)	Yes
Paediatric intensive care (PICANet)	NA
Paediatric pneumonia (British Thoracic Society)	Yes
Acute	
Audit title	CHFT Participation
Adult community acquired pneumonia (British Thoracic Society)	Yes
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes
Emergency use of oxygen (British Thoracic Society)	Yes
National Joint Registry (NJR)	Yes
Non-invasive ventilation - adults (British Thoracic Society)	Yes
Renal colic (College of Emergency Medicine)	Yes
Severe trauma (Trauma Audit & Research Network, TARN)	Yes
Blood and transplant	
Audit title	CHFT Participation
Intra-thoracic transplantation (NHSBT UK Transplant Registry)	NA
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA: a) O neg blood use (2010/11) b) Medical use of blood (2011/12) c) Bedside transfusion (2011/12) d) Platelet use (2010/11)	 Yes Yes Yes Yes
Potential donor audit (NHS Blood & Transplant)	Yes

Cancer	
Audit title	CHFT Participation
Bowel cancer (NBOCAP)	Yes
Head and neck oncology (DAHNO)	NA
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes
Heart	
Audit title	CHFT Participation
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes
Adult cardiac surgery audit (ACS)	NA
Cardiac arrhythmia (HRM)	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	NA
Coronary angioplasty	Yes
Heart failure (HF)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes
Pulmonary hypertension (Pulmonary Hypertension Audit)	NA
Long term conditions	
Audit title	CHFT Participation
Adult asthma (British Thoracic Society)	Yes
Bronchiectasis (British Thoracic Society)	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Inflammatory bowel disease (IBD)	Yes
National Review of Asthma Deaths (NRAD)	Yes
Pain database	Yes
Renal replacement therapy (Renal Registry)	NA
Renal transplantation (NHSBT UK Transplant Registry)	NA
Mental Health	
Audit title	CHFT Participation
National audit of psychological therapies (NAPT)	NA
National Audit of Schizophrenia (NAS) Prescribing Observatory for Mental Health (POMH)	NA

Older People	
Audit title	CHFT Participation
Carotid interventions audit (CIA)	Yes
Fractured neck of femur	Yes
Hip fracture database (NHFD)	Yes
National audit of dementia (NAD)	Yes
Parkinson's disease (National Parkinson's Audit)	Yes
Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13	 Yes Yes
Other	
Audit title	CHFT Participation
Elective surgery (National PROMs Programme)	Yes
National Confidential Enquiries	
Audit title	CHFT Participation
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths: Subarachnoid Haemorrhage Alcohol related liver Disease Bariatric Surgery Cardiac Arrest Procedures	 Yes Yes Yes Yes
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust did not participate in and reasons during 2012/13 are as follows:

Audit title	CHFT Participation	Reason	Projected date of commencement
SINAP	No	Joined SSNAP April 2012	April 2012

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust participated in, and for which data collection was completed during 2012/13, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Women's & Children's Health			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Epilepsy 12 audit (Childhood Epilepsy)	Yes	25	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	477	100%
Paediatric asthma (British Thoracic Society)	Yes	17	All cases in time period
Paediatric fever (College of Emergency Medicine)	Yes	100	100%
Paediatric pneumonia (British Thoracic Society)	Yes	16	All cases in time period

Acute			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Adult community acquired pneumonia (British Thoracic			
Society)	Yes	67	All cases in time period
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%	Ongoing
Emergency use of oxygen (British Thoracic Society)	Yes	18	All cases in time period
National Joint Registry (NJR)	Yes	920	Ongoing
Non-invasive ventilation - adults (British Thoracic Society)	Yes	18	All cases in time period
Renal colic (College of Emergency Medicine)	Yes	100%	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	100%	100%
Blood and transplant			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA: a) O neg blood use (2010/11) b) Medical use of blood (2011/12) c) Bedside transfusion (2011/12) d) Platelet use (2010/11)	 Yes Yes Yes Yes	 19 74 50 28	 100% 100% 100% 100%
Cancer			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	100%	70%
Head and neck oncology (DAHNO)	NA	NA	NA
Lung cancer (NLCA)	Yes	296	100%
Oesophago-gastric cancer (NAOGC)	Yes	100%	Ongoing
Heart			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%	100%
Cardiac arrhythmia (HRM)	Yes	257	100%
Heart failure (HF)	Yes	458	100%
National Cardiac Arrest Audit (NCAA)	Yes	32	100%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	100%	Ongoing

Long term conditions			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Adult asthma (British Thoracic Society)	Yes	48	All cases in time period
Bronchiectasis (British Thoracic Society)	Yes	61	All cases in time period
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	108	100%
Diabetes (Paediatric) (NPDA)	Yes	100%	100%
Inflammatory bowel disease (IBD)	Yes	43	100%
National Review of Asthma Deaths (NRAD) (5 year project)	Yes	100%	Ongoing
Pain database	Yes	100%	Ongoing
Mental Health			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
National audit of psychological therapies (NAPT)	NA	NA	NA
National Audit of Schizophrenia (NAS) Prescribing Observatory for Mental Health (POMH)	NA	NA	NA
Older people			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Carotid interventions audit (CIA)	Yes	100%	Ongoing
Fractured neck of femur	Yes	50	100%
Hip fracture database (NHFD)	Yes	466	100%
National audit of dementia (NAD)	Yes	79	99%
Parkinson's disease (National Parkinson's Audit)	Yes	40	100%
Sentinel Stroke National Audit Programme (SSNAP) - programme combines the following audits, which were previously listed separately in QA: a) Sentinel stroke audit (2010/11, 2012/13) b) Stroke improvement national audit project (2011/12, 2012/13	Yes No	60	100%
Other			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Elective surgery (National PROMs Programme)	Yes	100%	Ongoing
National Confidential Enquiries			
Audit title	CHFT Participation	Audit Sample	% Cases submitted
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths: Subarachnoid Haemorrhage Alcohol related liver Disease Bariatric Surgery Cardiac Arrest Procedures	Yes Yes Yes Yes	1 6 6 2	100% 100% 83% 100%
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes	2	100%

The reports of 21 national clinical audits were reviewed by the provider in 2012/13 and Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Inf ammatory Bowel Disease (IBD) – The Trust has taken part in the IBD national audit for the initial audit back in 2006. This audit looked at the level of care provided to patients with IBD.

One of the local actions off the back of this audit was to establish patients' views on the IBD service provided. The Experience Based Design (EBD) model was used to carry out this action and this involved the Trust working with patients, carers and staff to design the best possible care experience for our patients. The EBD model utilises various steps in the process of designing best possible care experience. The first step was to find out what patients liked and didn't like about the service. As a Trust we wanted to learn more about how the IBD service looks through patients eyes, by listening to their stories and experiences. All of this information was collated and it is hoped then that their stories and experiences will be used to identify important areas for action and to decide what improvements to make.

MINAP 2012

Local recommendation from national results

The NICE guidance states that all patients having an Myocardial Infarction (MI) should have their left ventricular function assessed. Our report shows that locally 62% of patients do not have their Left Ventricular (LV) assessed by echocardiogram with only 21% having an inpatient test performed.

.

NICE clinical guideline 48 for 'MI: secondary prevention', states that 'Assessment of left ventricular function is recommended in all patients who have had an MI'.

Action: To interrogate the data further to determine if there are identifiable reasons why patients have not had assessment of their LV function, in line with NICE guidance.

Some have echo/LV done by angiogram that don't get picked up on. Results presented at the cardiology audit. The process has changed now and the Acute Coronary Syndrome nurses can request Echo and so most MI patients are now having an echo as an inpatient.
The data from this year MINAP hopefully will represent that, although the change has only been within the last 6 months.

" I am passionate about the NHS and passionate about wanting the NHS to be delivering the best care for its patients that it can"

Joanne Machon, midwife selected for NHS leadership course

Parkinson's Disease (PD) National Audit 2011

Results published June 2012 – action planning taken place:

The Huddersfield Site compared favourably against the National results for "Patient Management".

- Similar gender mix to national figures
- HRI patients approx 5 years older than national average
- Similar length of time living with PD to national figures
- 100% of HRI patients had had a specialist nurse assessment within the past

12 months compared to a national figure of 75%

- 3% HRI patients are currently untreated compared to 3.6% nationally
- 100% HRI patients treated within NICE guidance options (98% national)

Work is ongoing to further improve PD services. Calderdale was represented in the 2012 audit for the first time. Findings to be presented to Integrated Care and Community Board in March 2013:

- A concerted effort should be made to reach Black and Asian Groups within the Huddersfield area. Information is available in various languages and should be available in the Outpatients Department Posters can be obtained from Head Office of PDUK & distributed to all local GP surgeries for display.
- Evidence that 10% HRI patients on dopamine agonists are not monitored for compulsive behaviour. Current information regarding Impulse Control Disorder is available from PDUK. Along with this are questionnaires regarding previous traits and disclaimers. These need to be approved for use by the Trust (Medicines Management committee) and can then be introduced
- Both Physiotherapy and Occupational therapy also took part in 2011 Audit. All findings to be combined.

Other National Clinical Audits the Trust has participated in during 2012/13:
BECOM - National Audit Symptomatic Breast Cancer
National Breast Screening Programme
UK National Bariatric Surgery Registry
Consultant Sign-Off
NAP 5: Accidental Awareness during General Anaesthesia (AAGA)
Potential Donor
National Thyroid and Parathyroid Audit (BAES)
Diabetic Retinopathy Screening (KPI)
National audit of Avascular Necrosis / Bisphosphonate Related Jaw Necrosis (BRONJ)
Mid-Urethral Tapes (BAUS)
Nephrectomy Surgery (BAUS)
PCNL (BAUS)
National audit of intermediate care
National clinical audit of sample collection and labelling
UK wide Insulin Pump audit - Adults & Paeds (NHS Diabetes)
Facing the Future (RCPCH)
UK Treat to Target - Rheumatoid Arthritis

The reports of 100 local clinical audits were reviewed by the provider in 2012/13 and Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Gallbladder Pathway – Acute gallbladder stone disease is a common and a severe pathology that gets fewer resources in the acute admission to other pathologies. As a result, an increase in the number of readmissions, progression of disease, complications and death occurs. Evidence base suggests that complete management in the acute episode in optimal to prevent the above mentioned. The clinical guidelines advocate the treatment of gallstone pancreatitis in the same admission or within two weeks from discharge.

The main aims and objectives are - multi-disciplinary inception, development and implementation of a protocol for the management of the acute gallbladder stone disease in Calderdale and Huddersfield NHS Trust.

An approved acute gallbladder stone disease protocol has been agreed and implemented in the Trust since January 2012 the results showed that for patients diagnosed with Biliary Colic/Cholecystitis 29 (57%) followed the protocol. Patients diagnosed with gall stone pancreatitis 14 (56%) followed the protocol. Patients diagnosed with Common Bile Duct stone/abnormal Liver Function Test 9 (40%) used the protocol.

Recommendation and Action Plan: (1) Increase acute theatre capacity (2) continue dissemination of the protocol via audit (3) implementation of the protocol to new clinical staff (4) re-audit.

Conclusion: Acute gallbladder stone disease is a common and severe condition its management should be done acutely. However, this attracts the use of many resources whose integration and effective use results in optimal outcome for the patient and increased revenue for the Trust.

The use of antibiotic prophylaxis in orthopaedic elective surgery (Fracture Neck of Femur) – An audit of antibiotic prophylaxis in orthopaedic elective surgery was carried out in the spring of 2012 and was presented at the July clinical governance meeting. The findings caused concern particularly about the range of antibiotics used and the lack of comprehensive documentation of patient fluid balances. The results were shared with the Microbiology team and a Consultant Microbiologist gave a presentation around the audit results at the September meeting which resulted in agreement about the appropriate antibiotic treatment regime as prophylaxis and as post-procedure recovery.

Off the back of this audit the following changes in practice have been agreed for all elective and trauma cases with implants:

Flucloxacillin 2g at induction and 3 doses (1g) 6 hourly post operative

Gentamicin 2mg/kg single dose at induction

* If day cases then single shot regime of above with no post operative doses

If penicillin allergy/ MRSA + / Revision Total Hip Replacement/Total Knee Replacement

Teicoplanin 400mg single dose at induction
Gentamicin 2mg/kg single dose

If Chronic Kidney Disease stage 3 / 4:

Augmentin 1.2 g at induction and 2 doses (1.2g) 8 hourly post operative

A further audit will be undertaken focussing on the fluid management of orthopaedic trauma patients. Its objectives will be to establish benchmark performance information and to improve patient safety through the production of a standard operating procedure for fluid balance management in orthopaedic trauma patients.

NPSA Alert re Safer use of Gentamicin in Neonates

Gentamicin is a broad spectrum aminoglycoside antibiotic that is widely used as the first choice antibiotic for the treatment of neonatal infection. Patient safety incidents have been reported involving administration of gentamicin at the incorrect time, prescribing errors and issues relating to blood level monitoring.

NHS organisations, clinical directors and those responsible for the provision of neonatal services should ensure that compliance with the care bundle is measured daily for each patient in the sample group until full compliance for all patients receiving gentamicin is achieved.

Over the past 18 months the Trust has made significant improvements to ensure compliance with the IV Gentamicin care bundle. It is re-assuring to note that there have been no recorded incidents of overdosing as detailed in the original National Patient Safety Agency. However, the audit has highlighted some areas for further improvement to ensure full compliance.

* Further improvement in completion of nursing documentation on Neo Natal Uuit (NNU). This is to be addressed at NNU staff meetings
* Address issue of re-siting of cannulas in a timely manner by junior doctors on ward 1D and 9. This is to be taken to Neonatal Forum for discussion & action planning with Consultant Paediatricians in May 2013
* Re-audit data as soon as possible to maintain compliance – to start on May 7th 2013 for 14 weeks

Calderdale and Huddersfield NHS

NHS Foundation Trust

Accounts 2012/13

Your Care
Our Concern

Pride • Patients • People • Partnerships

Calderdale & Huddersfield NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2013, have been prepared by the Calderdale and Huddersfield NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006

Owen Williams (Chief Executive)
May 2013

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 authoriastion, 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

Owen Williams, Chief Executive

Date: May 2013

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 2013 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 Provider Licence.

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

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 and Risk 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 and Families
- Medicine
- Surgery and Anaesthetics
- Diagnostic and Therapeutic Services

In addition there is a separate division for Estates and Facilities, led by an Executive Director, to cover 'hotel' services and safe management of the estate.

Corporate functions 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 Management 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. Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit and Risk Committee.

In addition to this, I recognise that effective training is essential in the management of risk and this is demonstrable at all levels within the organisation.

At an operational level the Trust has in place well developed programmes of generic and specific risk management training. We have reviewed and refreshed the mandatory training programme to ensure that it continues to meet the needs of all staff.

Risk is considered to be an integral part of the Trust's Organisational Development and training strategy and is included in key training programmes. This ties into our Appraisal and Mandatory training policies, as well as being actively encouraged through our staff engagement strategy – itself a key driver to ensure candour and provide 'early warning' signals of potential problem areas.

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, before risk mitigation.

The key principles of the risk and control framework, are that:

- The same process applies to all types of risk.
- All levels and every part of the Trust will carry out a system of self assessment for the identification and quantification of risk.
- Risks with their original risk rating, treatment plan and residual risk rating will be documented in operational risk registers, with risks rated 15 or above escalated to the corporate risk register.

Operational risk registers are maintained in every ward and department, and for time limited projects. Divisional risk registers consolidate directorate risks scoring 8 or above and add any additional over arching business risks to the division. Divisional risk registers are cross-referenced to the divisional business plan.

Internal assurance as to the effectiveness of this system of control is provided through the operational management system by way of management checks. In addition, the Risk, Compliance and Assurance Committee monitors the Compliance Register and Risk Register, and performance against national risk, and safety standards on my behalf. Board Level Assurance is provided by a scrutinising governance system which includes the Quality Assurance Board, and Audit and Risk Committee, both supported by Internal, External, and Clinical Audit. These arrangements pick up Risks with an 'unmitigated' score of 15 or above.

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.

Key elements of Board level focus include (but are not linked to), Never Events; Information Governance; Incident reporting and staff feedback.

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.

The Trust positively encourages incident reporting. Incidents are reported from all services, by all staff groups. Many of the reported incidents do not result in harm. However, information from incidents is analysed, to identify trends and areas for improvement. This data is considered by Risk, Compliance and Assurance Committee, Board of Directors, and Divisional Safety and Quality Boards via Learning from Experience reports.

In 2013/14 we are moving to a web based system so that staff can electronically report incidents as they occur. This will mean that "real time" information is available to identify any safety, financial, compliance, performance or patient experience issues.

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.

The three areas where significant internal control issues have been identified are as follows:

a) As regards Care Quality Commission's registration, it must be acknowledged that the Foundation Trust is currently not fully compliant with one of its requirements. Compliance inspections have shown that we are not compliant with Regulation 20 of the Regulated Activity Regulations 2010. The CQC have issued an enforcement notice requiring compliance by 31 May 2013. The Trust has taken some immediate actions and has a detailed action plan in place, to ensure compliance by 31 May. Essentially this notification relates to the accuracy of the patient record. There has been no evidence of harm or poor standards of care.

Annual Governance Statement (continued)

b) In addition, the Trust has received an enforcement notice from West Yorkshire Fire and Rescue Service requiring us to be compliant with relevant fire safety legislation on the HRI site. An agreed action plan to correct deficiencies is being implemented.

c) Finally, an information governance incident occurred which required reporting to the Information Commissioners Office. A ward handover list was found outside on the ground and handed back to the Trust. Handover sheets are now being removed from the wards.

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.

On the subject of 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, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex, sexual orientation.

Similarly regarding the physical 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.

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

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

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

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

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

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.

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. The Trust follows Monitor's 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 the key part of our discussions on business matters and business decisions and the Board receives updates on performance/indicators regularly, including real patient feedback.

Complementary to this, we actively engage open dialogue with our Membership Council on all matters relating to patient safety and experience. This also applies to our commissioners, particularly in the design and performance management of CQUIN standards. Finally, it must be acknowledged that our Programme Management Office which supports our financial strategy makes decisions based upon quality impact assessments as well as on financial grounds.

We have a number of quality improvement programmes underway at any time, lead by senior clinicians, supported by quality improvement specialists and information specialists. We use improvement methodologies developed by organisations such as the LEAN Academy and the Institute for Healthcare Improvement

There has been wide engagement with Stakeholders including staff and members in developing our priorities, and with patients through

surveys and complaints and patient safety incidents.
Quality 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 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 and Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Executive Management Team has identified the Trust's principal objectives and the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in the Trust's Assurance Framework document. This is monitored by the Audit amd Risk Committee and the Board of Directors.

These documents and internal and external audits of specific areas of internal control provide the Board of Directors with the information it requires to gain assurance that the Trust is meeting its objectives to protect patients, staff the public and other stakeholders against risks of any kind: which allows the Board to support me in signing this Annual Governance Statement.

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

The Quality Assurance Board monitors selected quality metrics, and ensures that the Foundation Trust has robust systems in place to learn from experience. It receives reports from specialist governance committees e.g. Safeguarding: Information Governance; Medicines Management; Risk Compliance Assurance Committee, and assures itself that Divisional Quality Boards are assuring themselves on the quality of their services. The Quality Assurance Board reports to the Board of Directors.

The Risk Compliance and Assurance Committee, receives regular reports from specialist committees and functions and considers risk registers and the Trust's compliance with national risk and safety standards. It also considers the detail of incidents and complaints to provide assurance that any trends are identified and improvement work identified.

A Non-Executive Director chairs the Audit and Risk Committee. Its role is to review the establishment of an effective system of internal control and risk management and provide an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity supported by the internal auditors who provide opinions on compliance with standards and the systems of internal control. Internal Audit have reviewed elements of the system of internal control including the assurance framework, self assessment of performance against the Essential standards of Quality and Safety, clinical governance and corporate governance.

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

a) Patient Record Keeping
b) Transportation/delivery of medication
c) Medical Devices Management
d) Staff Training
e) Dealing with external recommendations
f) Vehicles and fuel

All the above are scrutinised by the Audit and Risk Committee.

Conclusion
The system of internal control has been in place in Calderdale and Huddersfield NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts. In outlining the full extent of the systems, the report also acknowledges that three internal control issues have arisen in year which are now being corrected; Records Management, Fire Safety and Information Governance.

In summary I am assured that the NHS foundation trust has an overall sound system of internal controls in place, which continues to evolve to ensure open/shared learning and candour. This is designed to manage the key organisational objectives and minimise the NHS foundation trust's exposure to risk. There are however weaknesses in the system in a few areas which are being addressed. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Signed.

Chief Executive

May 2013

Independent Auditor's Report to the Board of Governors of Calderdale and Huddersfield NHS Foundation Trust

We have audited the financial statements of Calderdale and Huddersfield NHS Foundation Trust for comprising of the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes for the year ended 31 March 2013. These financial statements have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2012/13.

This report is made solely to the Board of Governors of Calderdale and Huddersfield NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of Calderdale and Huddersfield NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure for the year then ended; and
- have been prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Calderdale and Huddersfield NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Trevor Rees for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St James' Square
Manchester
M2 6DS

29 May 2013

STATEMENT OF COMPREHENSIVE INCOME

	note	2012/13	2011/12
		£000	£000
Operating Income from continuing operations	3	**351,314**	341,260
Operating Expenses of continuing operations	4	**(339,818)**	(323,667)
OPERATING SURPLUS / (DEFICIT)		**11,496**	17,593
FINANCE COSTS			
Finance income	9	**263**	215
Finance expense - financial liabilities	10	**(10,724)**	(10,486)
Finance expense - unwinding of discount on provisions		**(99)**	(75)
PDC Dividends payable		**(3,224)**	(3,525)
NET FINANCE COSTS		**(13,784)**	(13,871)
Share of Profit / (Loss) of Associates/Joint Ventures accounted for using the equity method		**-**	-
Corporation tax expense	8	**-**	-
Surplus/(Deficit) from continuing operations		**(2,288)**	3,722
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	-
SURPLUS/(DEFICIT) FOR THE YEAR		**(2,288)**	3,722
Other comprehensive income			
Impairments		**(1,520)**	(4,163)
Revaluations		**2,221**	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		**-**	-
Other reserve movements		**-**	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**(1,587)**	2,623
Prior period adjustment		**-**	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(1,587)**	2,623
Note: Allocation of Profits/(Losses) for the period:		**2012/13**	2011/12
		£000	£000
(a) Surplus/(Deficit) for the period attributable to:			
(i) minority interest, and		**-**	-
(ii) owners of the parent.		**(2,288)**	3,722
TOTAL		**(2,288)**	3,722
(b) total comprehensive income/ (expense) for the period attributable to:			
(i) minority interest, and		-	-
(ii) owners of the parent.		**(1,587)**	2,623
TOTAL		**(1,587)**	**2,623**

The notes on the following pages form part of these Accounts.
Operating income for 2012/13 and 2011/12 includes an exceptional item relating to the reversal of impairments on property, plant and equipment of £214,000 and £3,695,000 respectively. Operating expenses for 2012/13 and 2011/12 include exceptional items relating to impairments on property, plant and equipment of £6,318,000 and £969,000 respectively.
The surplus positions for 2012/13 and 2011/12, excluding these non-cash exceptional items, are £3,816,000 and £937,000 respectively.

STATEMENT OF FINANCIAL POSITION

	note	31 March 2013 £000	31 March 2012 £000
Non-current assets			
Intangible assets	12	**412**	482
Property, plant and equipment	13	**200,763**	206,606
Investment Property		**-**	-
Investments in associates (and joined controlled operations)		**-**	-
Other investments		**-**	-
Trade and other receivables	17	**1,943**	1,956
Other Financial assets		**-**	-
Other assets		**-**	-
Total non-current assets		**203,118**	209,044
Current assets			
Inventories	16	**5,217**	5,489
Trade and other receivables	17	**11,622**	10,396
Other financial assets		**-**	-
Non-current assets for sale and assets in disposal groups	15	**939**	1,420
Cash and cash equivalents	18	**33,407**	20,306
Total current assets		**51,186**	37,611
Current liabilities			
Trade and other payables	19	**(34,210)**	(26,508)
Borrowings	20	**(1,908)**	(1,771)
Other financial liabilities		**-**	-
Provisions	23	**(6,222)**	(2,036)
Other liabilities	22	**(725)**	(1,149)
Liabilities in disposal groups		**-**	-
Total current liabilities		**(43,065)**	(31,464)
Total assets less current liabilities		**211,239**	215,191
Non-current liabilities			
Trade and other payables	19	**(367)**	(457)
Borrowings	20	**(86,908)**	(88,758)
Other financial liabilities		**-**	-
Provisions	23	**(2,903)**	(3,190)
Other liabilities	22	**(1,653)**	(1,791)
Total non-current liabilities		**(91,831)**	(94,196)
Total assets employed		**119,408**	120,995
Financed by (taxpayers' equity)			
Financed by (taxpayers' equity)			
Minority Interest		**-**	-
Public Dividend Capital		**111,899**	111,899
Revaluation reserve		**29,605**	29,786
Available for sale investments reserve		**-**	-
Other reserves		**-**	-
Merger reserve		**-**	-
Income and expenditure reserve		**(22,096)**	(20,690)
Total taxpayers' equity		**119,408**	120,995

Signed : Date : May 2013

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 2012	**120,995**	**111,899**	**29,786**	**(20,690)**
Surplus/(deficit) for the year	**(2,288)**	**-**	**-**	**(2,288)**
Transfers by absorption: transfers between reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Impairments	**(1,520)**	-	**(1,520)**	-
Revaluations - property, plant and equipment	**2,221**	-	**2,221**	-
Revaluations - intangible assets	-	-	-	-
Revaluations - financial assets	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-
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	-	-	**(882)**	**882**
Taxpayers' Equity at 31 March 2013	**119,408**	**111,899**	**29,605**	**(22,096)**

	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 by absorption: transfers between reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Impairments	(4,163)	-	(4,163)	-
Revaluations - property, plant and equipment	3,064	-	3,064	-
Revaluations - intangible assets	-	-	-	-
Revaluations - Financial assets	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-
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	-	-	(374)	374
Other reserve movements	120,995	111,899	29,786	(20,690)

STATEMENT OF CASH FLOWS

	2012/13	2011/12
	£000	£000
Cash f ows from operating activities		
Operating surplus/(deficit) from continuing operations	11,496	17,593
Operating surplus/(deficit) from discontinued operations	-	-
Operating surplus/(deficit)	**11,496**	**17,593**
Non-cash income and expense:		
Depreciation and amortisation	9,254	8,998
Impairments	6,318	969
Reversals of impairments	(214)	(3,695)
(Gain)/Loss on disposal*	469	649
Non-cash donations/grants credited to income	-	-
Interest accrued and not paid	-	-
Dividends accrued and not paid or received	-	-
Amortisation of PFI credit	-	-
(Increase)/Decrease in Trade and Other Receivables	(1,098)	846
Increase/(Decrease) in Other Assets	-	-
(Increase)/Decrease in Inventories	272	(762)
Increase/(Decrease) in Trade and Other Payables	6,485	3,742
Increase/(Decrease) in Other Liabilities	(562)	(2,183)
Increase/(Decrease) in Provisions	3,899	2,293
Tax (paid) / received	(164)	118
Movements in operating cash flow of discontinued operations	-	-
Movements in operating cash flow in respect of Transforming Community Services transaction	-	-
Other movements in operating cash flows	879	125
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**37,034**	**28,693**
Cash f ows from investing activities		
Interest received	263	177
Purchase of financial assets	-	-
Sale of financial assets	-	-
Purchase of intangible assets	(55)	(208)
Sales of intangible assets	-	-
Purchase of Property, Plant and Equipment	(9,249)	(7,280)
Sales of Property, Plant and Equipment	954	5
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	**(8,087)**	**(7,306)**
Cash f ows from financing activities		
Public dividend capital received	-	-
Public dividend capital repaid	-	-
Loans received from the Foundation Trust Financing Facility	-	-
Loans received from the Department of Health	-	-
Other loans received	-	-
Loans repaid to the Foundation Trust Financing Facility	(562)	(562)
Loans repaid to the Department of Health	-	-
Other loans repaid	-	-
Capital element of finance lease rental payments	(1,209)	(1,209)
Other capital receipts	-	-
Capital element of Private Finance Initiative Obligations	-	-
Interest paid	(270)	(298)
Interest element of finance lease	-	-
Interest element of Private Finance Initiative obligations	(10,464)	(10,201)
PDC Dividend paid	(3,340)	(3,836)
Cash flows attributable to financing activities of discontinued operations	-	-
cash flows from (used in) other financing activities	-	-
Net cash generated from/(used in) financing activities	**(15,845)**	**(16,106)**
Increase/(decrease) in cash and cash equivalents	**13,102**	**5,281**
Cash and Cash equivalents at 1 April	20,306	15,025
Cash and Cash equivalents at 31 March	33,408	20,306

*Monitor now require (Gains)/loss on disposals to be disclosed separately in the cash flow statement. To aid in year comparison, the 2011/12 figure has been re-categorised, £649k originally categorised as Other movements in operating cash flows and has been re-categorised as (Gains)/loss on disposal.

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 2012/13 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'.

(Until 31 March 2013, NHS Charitable funds considered to be subsidiaries are excluded from consolidation in accordance with the accounting direction issued by Monitor).

Joint Ventures

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

Joint ventures are accounted for using the equity method.

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

1.3 Income

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

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

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

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

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Given the low value of annual leave carried forward by employees across periods, and as this value does not change significantly between financial years, the cost of annual leave earned but not taken by employees at the end of the period is not recognised in the financial statements.

Pension costs

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

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

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

1.5 Expenditure on other goods and services

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

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative

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

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

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

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

Measurement

Valuation

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

All assets are measured subsequently at fair value.

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

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

In addition, as a result of changes in replacement costs and the property market, additional interim revaluations were undertaken as at 31 March 2013 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.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve when the impairment reversal is recognised.

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

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

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:

– management are committed to a plan to sell the asset;
– an active programme has begun to find a buyer and complete the sale;
– the asset is being actively marketed at a reasonable price;
– the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
– the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

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

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

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

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

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

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

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

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

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

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

Expenditure on research is not capitalised.

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

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;

- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

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

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

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

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

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

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

1.9 Inventories
Inventories are valued at the lower of cost and net realisable value. The Cost of inventories is measured using the First In, First Out (FIFO) method. The cost valuation is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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

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

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

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

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

Classification and Measurement
Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other Financial liabilities'.

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

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

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

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

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

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

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

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are

impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

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

1.11 Leases

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk- adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at Note 23.3.

Non-clinical risk pooling

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

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23.4 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23.4, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.14 Public dividend capital

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

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

1.15 Value Added Tax

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

1.16 Corporation Tax

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

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

Note 2 Segmental Analysis

All of Calderdale and Huddersfield NHS Foundation Trust's activities are in the provision of healthcare, which is an aggregate of all the individual specialty components included therein. Similarly, the large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore on this basis one segment of 'Healthcare' is deemed appropriate.

The operating results of the Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a single operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers one segment of healthcare in its decision-making process.
The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

Note 3 Operating Income

Note 3.1 Operating Income by classification

	2012/13	2011/12
	£000	£000
Income from activities		
Elective income	**52,260**	53,940
Non elective income	**89,190**	88,883
Outpatient income	**45,650**	45,747
A & E income	**13,260**	12,990
Other NHS clinical income	**111,350**	99,538
Private patient income	**553**	369
Other non-protected clinical income	**5,464**	4,781
Total income from activities	**317,727**	306,248
Other operating income		
Research and development	**1,119**	1,302
Education and training	**7,967**	7,465
Received from NHS charities: Receipt of grants/donations for capital acquisitions - Donation (i.e. receipt of donated asset)	**7**	623
Received from NHS charities: Other charitable and other contributions to expenditure	**403**	-
Non-patient care services to other bodies	**10,708**	8,531
Other	**13,108**	13,336
Reversal of impairments of property, plant and equipment	**214**	3,695
Rental revenue from operating leases - Minimum lease receipts	**59**	56
Rental revenue from operating leases - contingent rent	**2**	4
Total other operating income	**33,587**	35,012
	351,314	341,260

Note 3.2 Private patient income

The statutory limitation on private patient income in section 44 of the 2006 Act was repealed with effect from 1 October 2012 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

Note 3.3 Operating lease income

		Restated*	Original
	2012/13	2011/12	2011/12
	£000	£000	£000
Operating Lease Income			
Rental revenue from operating leases - Minimum lease receipts	**59**	56	60
Rental revenue from operating leases - contingent rent	**2**	4	4
Rental revenue from operating leases - Other	**-**	-	-
TOTAL	**61**	60	64
Future minimum lease payments due			
- not later than one year;	**32**	30	30
- later than one year and not later than five years;	**16**	16	16
- later than five years.	**28**	28	28
TOTAL	**76**	74	74

*The Rental revenue from operating leases - Minimum lease receipts for 2011/12 has been restated as it included £4k too much in error.

Note 3.4 Operating Income by type

	2012/13	2011/12
	£000	£000
Income from activities		
NHS Foundation Trusts	**(247)**	1
NHS Trusts	**177**	239
Strategic Health Authorities	**19**	112
Primary Care Trusts	**311,579**	300,695
Local Authorities	**332**	414
Department of Health - other	**62**	51
NHS Other	**83**	-
Non NHS: Private patients	**553**	369
Non-NHS: Overseas patients (non-reciprocal)	**86**	-
NHS injury scheme (was RTA)	**1,926**	1,968
Non NHS: Other	**3,158**	2,399
Total income from activities	**317,727**	306,248
Other Operating Income (See note 3.1 for break down)	**33,587**	35,012
TOTAL OPERATING INCOME	**351,314**	341,260
Of Which		
Related to Continuing Operations	**351,314**	341,260
Related to Discontinued Operations	**-**	-
Analysis of Income from activities: Non-NHS Other		
Ministry of Defence	**-**	-
Other government departments and agencies	**-**	-
Other	**3,158**	2,399
Total	**3,158**	2,399

* Other Operating income of £13.1m includes £4.2m sales of manufactured pharmaceutical products and £1.3m property rental income, £0.9m catering income (In 2011/12 the comparative figures were £4.1m sales of manufactured pharmaceutical products and £0.4m property rental income, £1.3m catering income).

Note 4 Operating Expenses

	2012/13	2011/12
	£000	£000
Services from NHS Foundation Trusts	**13**	236
Services from NHS Trusts	**1,673**	2,018
Services from PCTs	**47**	158
Services from other NHS Bodies	**29**	2
Purchase of healthcare from non NHS bodies	**1,360**	675
Employee Expenses - Executive directors	**1,025**	935
Employee Expenses - Non-executive directors	**155**	152
Employee Expenses - Staff	**213,019**	212,223
Supplies and services - clinical (excluding drug costs)	**29,078**	25,972
Supplies and services - general	**3,091**	2,874
Establishment	**4,959**	5,155
Research and Development - (Not Included in employee expenses)	**29**	4
Transport	**372**	359
Premises	**24,946**	23,312
Increase / (decrease) in bad debt provision	**1,276**	622
Increase in other provisions	**4,563**	2,764
Drugs	**23,468**	22,410
Rentals under operating leases - minimum lease receipts	**3,682**	2,926
Rentals under operating leases - sublease payments	**(6)**	(6)
Depreciation on property, plant and equipment	**9,129**	8,888
Amortisation on intangible assets	**125**	110
Impairments of property, plant and equipment	**6,318**	969
Audit fees	**-**	-
Audit services - statutory audit	**52**	68
Audit services - regulatory reporting	**19**	-
Other auditor remuneration - analysis in note 6.4	**-**	8
Clinical negligence	**7,307**	7,004
Loss on disposal of other property, plant and equipment	**469**	649
Consultancy costs *	**1,829**	1,104
Training, courses and conferences *	**912**	837
Redundancy (included in employee expenses)	**-**	153
Other	**879**	1,086
TOTAL	**339,818**	323,667
of Which		
Related to Continuing Operations	**339,818**	323,667
Related to Discontinued Operations	-	-

* In 2011/12 Consultancy and Training, Courses and Conferences costs were included within Other costs to aid year on year comparison they have be re-categorised.

Note 5 Employee Expenses

Note 5.1 Employee Expenses breakdown

	2012/13	Restated* 2011/12	Original 2011/12
	£000	£000	£000
Salaries and wages	**169,718**	172,074	172,227
Social security costs	**12,668**	12,819	12,819
"Pension costs - defined contribution plans			
Employers contributions to NHS Pensions "	**20,669**	20,977	20,977
Termination benefits	**1,714**	929	929
Agency/contract staff	**9,275**	6,359	6,359
TOTAL	**214,044**	213,158	213,311
included within:			
Analysed into Operating Expenditure			
Employee Expenses - Staff	**213,019**	212,223	212,223
Employee Expenses - Executive directors	**1,025**	935	935
Total Employee benefits excluding capitalised costs	**214,044**	213,158	213,158

* The Salaries and wages for 2011/12 have been restated as £153k for Non-Exec Director pay had been incorrectly included.

Note 5.1 Average number of employees (Whole Time Equivalent basis)

	2012/13	2011/12
	Number	Number
Medical and dental	**514**	505
Administration and estates	**1,223**	1,247
Healthcare assistants and other support staff	**996**	1,036
Nursing, midwifery and health visiting staff	**1,585**	1,601
Scientific, therapeutic and technical staff	**727**	761
Bank and agency staff	**215**	146
TOTAL	**5,260**	5,296

Note 5.3 Employee benefits

The Trust has not paid any Employee benefits in the 2012/13 or 2011/12 financial years.

Note 5.4 Early retirements due to ill health

	2012/13	2011/12
	Number	Number
No of early retirements on the grounds of ill health	**11**	3
	2012/13	**2011/12**
	£000	£000
Value of early retirements on the grounds of ill health	**590**	288

Note 5.5 Staff exit packages

	2012/13	2011/12
	Number	Number
Exit package cost band:		
< £10,000	**28**	14
£10,000 - £25,000	**34**	12
£25,001 - £50,000	**17**	10
£50,001 - £100,000	**4**	2
£100,001 - £150,000	**-**	-
£150,001 - £200,000	**-**	2
>£200,001	**-**	-
Total number of exit packages by type	**83**	40
	2012/13	2011/12
	£000	£000
Total resource cost	**1,714**	1,123

The Trust operated a time-limited 'Mutually Approved Resignation Scheme' (MARS) in 2012/13 and 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. In 2011/12 two exit packages were voluntary redundancy.

Note 6 Operating expenses - miscellaneous

Note 6.1 Operating leases

	2012/13	2011/12
	£000	£000
Minimum lease payments	**3,682**	2,926
Contingent rents	**-**	-
Less sublease payments received	**(6)**	(6)
TOTAL	**3,676**	2,920

Note 6.2 Arrangements containing an operating lease

	2012/13	2011/12
	£000	£000
Future minimum lease payments due:		
- not later than one year;	**3,253**	2,548
- later than one year and not later than five years;	**8,955**	7,893
- later than five years.	**19,796**	17,569
TOTAL	**32,004**	28,010
Total of future minimum sublease lease payments to be received as the balance sheet date	**48**	48

Note 6.3 Late Payment

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

Note 6.4 Audit Remuneration

	2012/13	2011/12
	£000	£000
Audit services- statutory audit	**52**	68
Audit services -regulatory reporting	**19**	-
Other auditor remuneration paid to the external auditor is analysed as follows:		
1. The auditing of accounts of any associate of the Trust	**-**	-
2. Audit-related assurance services	**-**	8
3. Taxation compliance services	**-**	-
4. All taxation advisory services not falling within item 3 above;	**-**	-
5. **internal** audit services (only those payable to the external auditor)	**-**	-
6. All assurance services not falling within items 1 to 5	**-**	-
7. Corporate finance transaction services not falling within items 1 to 6 above	**-**	-
8. All other non-audit services not falling within items 2 to 7 above	**-**	-
TOTAL	**71**	76

Note 7 Discontinued operations

The Trust had no discontinued operations to disclose in 2012/13 or 2011/12.

Note 8 Corporation Tax

The Trust has assessed that it is not liable for Corporation tax in 2012/13 or 2011/12.

Note 9 Finance income

	2012/13	2011/12
	£000	£000
Interest on bank accounts	**263**	215
Interest on loans and receivables	**-**	-
Interest on available for sale financial assets	**-**	-
Interest on held-to-maturity financial assets	**-**	-
Other	**-**	-
TOTAL	**263**	215

Note 10 Finance costs - interest expense

	2012/13	2011/12
	£000	£000
Loans from the Foundation Trust Financing Facility	**260**	285
Commercial loans	**-**	-
Overdrafts	**-**	-
Finance leases	**-**	-
Other	**-**	-
Finance Costs in PFI obligations		
Main Finance Costs	**7,178**	7,281
Contingent Finance Costs	**3,286**	2,920
TOTAL	**10,724**	10,486

Note 11 Impairment of assets

	2012/13	2011/12
	£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	-	-
Changes in market price	**7,838**	5,132
Reversal of impairments	**(214)**	(3,695)
TOTAL	**7,624**	1,437

Note 12 Intangible assets

Note 12.1 Intangible assets - 2012/13

	Total	"Software licences (purchased)"	Information technology (internally generated)	Intangible Assets Under Construction
	£000	£000	£000	£000
Valuation/Gross Cost at 1 April 2012 - as previously stated	**1,265**	**625**	**611**	**29**
Additions - purchased	**55**	**11**	**0**	**44**
Additions - Leased	-	-	-	-
Additions - donated	-	-	-	-
Additions - internally generated	-	-	-	-
Impairments	-	-	-	-
Reversal of Impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluations	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-
Disposals	-	-	-	-
Gross cost at 31 March 2013	**1,320**	**636**	**611**	**73**
Amortisation at 1 April 2012	**783**	**446**	**337**	-
Provided during the year	**125**	**38**	**87**	-
Impairments	-	-	-	-
Reversal of Impairments	-	-	-	-
Reclassifications	-	-	-	-
Revaluation surpluses	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-
Disposals	-	-	-	-
Amortisation at 31 March 2013	**908**	**484**	**424**	**0**

Note 12.2 Intangible assets - 2011/12

	Total	"Software licences (purchased)"	Information technology (internally generated)	Intangible Assets Under Construction
	£000	£000	£000	£000
Gross cost at 1 April 2011	1,058	447	611	-
Additions - purchased	207	164	-	43
Additions - Leased	-	-	-	-
Additions - donated	-	-	-	-
Additions - internally generated	-	-	-	-
Impairments	-	-	-	-
Reversal of Impairments	-	-	-	-
Reclassifications	-	14	-	(14)
Revaluations	-	-	-	-
Transferred to disposal group as asset held for sale	-	-	-	-
Disposals	-	-	-	-
Valuation/Gross cost at 31 March 2012	1,265	625	611	29
Amortisation at 1 April 2011	673	440	233	0
Provided during the year	110	6	104	0
Impairments	-	0	0	0
Reversal of Impairments	-	0	0	0
Reclassifications	-	0	0	0
Revaluation surpluses	-	0	0	0
Transferred to disposal group as asset held for sale	-	0	0	0
Disposals	-	0	0	0
Amortisation at 31 March 2012	783	446	337	0

Note 12.3 Intangible assets financing

	Total	"Software licences (purchased)"	Information technology (internally generated)	Intangible Assets Under Construction
	£000	£000	£000	£000
Net book value				
NBV - Purchased at 31 March 2013	**412**	152	187	73
NBV - Finance leases at 31 March 2013	**-**	-	-	-
NBV - Donated at 31 March 2013	**-**	-	-	-
NBV total at 31 March 2013	**412**	152	187	73
Net book value				
NBV - Purchased at 31 March 2012 (restated)	**482**	179	274	29
NBV - Finance Leases at 31 March 2012 (restated)	**-**	-	-	-
NBV - Donated at 31 March 2012 (restated)	**-**	0	0	0
NBV total at 31 March 2012	**482**	179	274	29

Note 12.4 Government grants
The Trust has no intangible assets acquired by government grants.

Note 12.5 Economic life of intangible assets
All of the Trusts intangible assets relate to software. The Trust has no intangible assets for Licenses & trademarks, Patents, Information Technology, Development expenditure, Goodwill or Intangible Assets under construction.

The estimated economic useful life of software is five years.

Note 13 Property, plant and equipment

Note 13.1 Property, plant and equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2012	**237,424**	**42,385**	**147,513**	**3,963**	**1,174**	**27,754**	**106**	**13,024**	**1,505**
Additions - purchased	**10,549**	**35**	**6,028**	**-**	**468**	**1,308**	**-**	**2,710**	**-**
Additions - leased		**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Additions - donated	**7**	**-**	**-**	**-**	**-**	**7**	**-**	**-**	**-**
Impairments	**(1,520)**	**(915)**	**(93)**	**(512)**	**-**	**-**	**-**	**-**	**-**
Reversal of impairments	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Reclassifications	**-**	**-**	**921**	**-**	**(1,209)**	**-**	**-**	**288**	**-**
Revaluations	**2,221**	**65**	**2,136**	**20**	**-**	**-**	**-**	**-**	**-**
Transferred to disposal group as asset held for sale	**(939)**	**(380)**	**-**	**(559)**	**-**	**-**	**-**	**-**	**-**
Disposals	**(4,867)**	**-**	**(576)**	**-**	**-**	**(4,177)**	**(36)**	**(78)**	**-**
Valuation/Gross cost at 31 March 2013	**242,875**	**41,190**	**155,929**	**2,912**	**433**	**24,892**	**70**	**15,944**	**1,505**
Accumulated depreciation at 1 April 2012	**30,818**	**-**	**-**	**-**	**-**	**20,269**	**106**	**9,142**	**1,301**
Provided during the year	**9,129**	**-**	**5,667**	**106**	**-**	**2,030**	**-**	**1,266**	**60**
Impairments	**6,318**	**145**	**5,873**	**300**	**-**	**-**	**-**	**-**	**-**
Reversal of impairments	**(214)**	**-**	**(214)**	**-**	**-**	**-**	**-**	**-**	**-**
Reclassifications	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Revaluation surpluses	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transferred to disposal group as asset held for sale	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Disposals	**(3,939)**	**-**	**(16)**	**-**	**-**	**(3,812)**	**(36)**	**(75)**	**-**
Accumulated depreciation at 31 March 2013	**42,112**	**145**	**11,310**	**406**	**-**	**18,487**	**70**	**10,333**	**1,361**

Note 13.2 Property, plant and equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£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 - Leased		-	-	-	-	-	-	-	-
Additions - donated	126	-	-	-	-	126	-	-	-
Impairments	(4,163)	(1,249)	(2,708)	(206)	-	-	-	-	-
Reversal of impairments	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	7,633	-	(8,343)	24	-	686	-
Revaluations	340	-	138	96	-	33	-	73	-
Transferred to disposal group as asset held for sale	(920)	(380)	-	(540)	-	-	-	-	-
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	-	-	-	-	-	-	-	-	-
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

Note 13.3 Property, plant and equipment financing

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value - 31 March 2013									
Owned	**119,143**	**40,310**	**64,467**	**2,506**	**209**	**5,911**	**-**	**5,596**	**144**
Finance Lease	**803**	**735**	**-**	**-**	**-**	**68**	**-**	**-**	**-**
PFI	**79,473**	**-**	**79,451**	**-**	**22**	**-**	**-**	**-**	**-**
Donated	**1,344**	**-**	**701**	**-**	**202**	**426**	**-**	**15**	**-**
NBV total at 31 March 2013	**200,763**	**41,045**	**144,619**	**2,506**	**433**	**6,405**	**-**	**5,611**	**144**
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

Note 13.4 Economic life of property, plant and equipment

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

Note 14 Protected assets

Note 14.1 Analysis of property, plant and equipment 31 March 2013

	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 2013	**96,030**	**3,742**	**92,288**	**-**	**-**	**-**	**-**	**-**	**-**
NBV - Unprotected assets at 31 March 2013	**104,733**	**37,303**	**52,331**	**2,506**	**433**	**6,405**	**-**	**5,611**	**144**
Total at 31 March 2013	**200,763**	**41,045**	**144,619**	**2,506**	**433**	**6,405**	**-**	**5,611**	**144**

Note 14.2 Analysis of property, plant and equipment 31 March 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

Note 14.3 NBV of property, plant and equipment in the revaluation reserve as at 31 March 2013

	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 2012	29,786	27,384	189	1,261	-	876	-	71	5
Movement in year	(181)	(1,098)	2,087	(705)	-	(466)	-	2	(1)
As at 31 March 2013	29,605	26,286	2,276	556	-	410	-	73	4

Note 14.4 NBV of property, plant and equipment in the revaluation reserve as at 31 March 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	-	-	49
Movement in year	(1,474)	(1,231)	129	(102)	-	(297)	-	71	(44)
As at 31 March 2012	29,786	27,384	189	1,261	-	876	-	71	5

Note 15 Assets held for sale

Note 15.1 Non-current assets for sale and assets in disposal groups - 2012/13

	Total	Intangible assets	Property, Plant and Equipment	PPE: Dwellings	Financial Investments
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2012	**1,420**	**-**	**880**	**540**	**-**
Plus assets classified as available for sale in the year	**939**	**-**	**380**	**559**	**-**
Less assets sold in year	**(1,420)**	**0**	**(880)**	**(540)**	**-**
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 2013	**939**	**-**	**380**	**559**	**-**

Note 15.2 Non-current assets for sale and assets in disposal groups 2011/12

	Total	Intangible assets	Property, Plant and Equipment	PPE: Dwellings	Financial Investments
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 11	500	-	500	-	-
Plus assets classified as available for sale in the year	920	-	380	540	-
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	-	880	540	-

Note 16 Inventories

Note 16.1 Inventories

	31 March 2013	31 March 2012
	£000	£000
Drugs	**1,795**	1,997
Work in progress	**196**	221
Consumables	**3,226**	3,271
TOTAL Inventories	**5,217**	5,489

Note 16.2 Inventories recognised in expenses

All Inventories are treated as expenditure.

Note 17 Trade and other receivables

Note 17.1 Trade receivables and other receivables

	Total	
	31 March 2013	31 March 2012
	£000	£000
Current		
NHS Receivables - Revenue	**5,932**	5,434
Other receivables with related parties - Revenue	**-**	427
Provision for impaired receivables	**(1,123)**	(468)
Prepayments (Non-PFI)	**1,947**	1,733
Accrued income	**803**	400
Interest Receivable	**38**	38
PDC dividend receivable	**303**	187
Other receivables	**972**	557
Other receivables - Capital	**2,750**	2,088
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**11,622**	10,396
Non-Current		
Provision for impaired receivables	**(354)**	(136)
Accrued income	**-**	796
Other receivables	**1,372**	1,296
Other receivables - Capital	**925**	-
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**1,943**	1,956

NHS Receivables falling due within one year includes £2,654,460 for incomplete spells of care provided at 31 March 2013 (£2,486,000 at 31 March 2012).

Note 17.2 Provision for impairment of receivables

	2012/13	2011/12
	£000	£000
At 1 April	**604**	759
Increase in provision	**1,458**	681
Amounts utilised	**(403)**	(777)
Unused amounts reversed	**(182)**	(59)
At 31 March	**1,477**	604

Note 17.3 Analysis of impaired receivables

	2012/13	2011/12
	£000	£000
Ageing of impaired receivables		
0 - 30 days	**274**	19
30-60 Days	**502**	26
60-90 days	**32**	36
90- 180 days (was "In three to six months")	**199**	184
180-360 days (was "Over six months")	**470**	339
Total	**1,477**	604
Ageing of non-impaired receivables past their due date		
0 - 30 days	**1,900**	1,183
30-60 Days	**419**	413
60-90 days	**29**	157
90- 180 days (was "In three to six months")	**26**	316
180-360 days (was "Over six months")	**2**	791
Total	**2,376**	2,860

Note 17.4 Finance lease receivables
The Trust had no Finance lease receivables in 2012/13 or 2011/12.

Note 18 Cash and cash equivalents

	2012/13	2011/12
	£000	£000
At 1 April	**20,306**	15,025
Net change in year	**13,101**	5,281
At 31 March	**33,407**	20,306
Broken down into:		
Cash at commercial banks and in hand	**106**	134
Cash with the Government Banking Service	**33,301**	20,172
Cash and cash equivalents as in SoFP	**33,407**	20,306
Bank overdraft - Government Banking Service	**-**	-
Bank overdraft - Commercial banks	**-**	-
Cash and cash equivalents as in SoCF	**33,407**	20,306

Note 18.1 Third party assets held by the NHS Foundation Trust

	2012/13	2012/13	2011/12	2011/12
	Bank Balances	Money on Deposit	Bank Balances	Money on Deposit
	£000	£000	£000	£000
At 1 April	**1**	-	1	**-**
Gross inflows	**18**	-	24	**-**
Gross outflows	**(17)**	-	(24)	**-**
At 31 March	**2**	-	1	**-**

Note 19 Trade and other payables

Note 19.1 Trade and other payables

	Total	Total
	Sunday, March 31, 2013	Saturday, March 31, 2012
	£000	£000
NHS payables - revenue	**374**	1,114
Amounts due to other related parties - revenue	**-**	2,651
Other trade payables - capital	**4,126**	2,825
Other trade payables - revenue	**10,585**	6,170
Other taxes payable	**4,171**	4,335
Other payables	**1,216**	1,117
Accruals*	**13,739**	8,296
TOTAL CURRENT TRADE AND OTHER PAYABLES	**34,210**	26,508
Non-current		
Other payables	**367**	457
TOTAL NON CURRENT TRADE AND OTHER PAYABLES	**367**	457

* In 2011/12 purchase order accruals were included in Other Payables these have been re-categorised for a year on year comparison, in 2012/13 these accruals have been included in Accruals.

Note 19.2 Early retirements detail included in NHS payables above
The Trust has no early retirement costs included in NHS Payables above.

Note 20 Borrowings

	31-March-13	31-March-12
	£000	£000
Current		
Loans from Foundation Trust Financing Facility	**562**	562
Obligations under finance leases	**34**	-
Obligations under Private Finance Initiative contracts	**1,312**	1,209
TOTAL CURRENT BORROWINGS	**1,908**	1,771
Non-current		
Loans from Foundation Trust Financing Facility	**5,069**	5,632
Obligations under finance leases	**25**	-
Obligations under Private Finance Initiative contracts	**81,814**	83,126
TOTAL OTHER NON CURRENT LIABILITIES	**86,908**	88,758

Note 21 Prudential borrowing

Note 21.1 Prudential borrowing limit

	2012/13	2011/12
	£000	£000
Total long term borrowing limit set by Monitor (per Schedule 5 of Trust's terms of Authorisation)	**90,529**	92,300
Working capital facility limit agreed by Monitor (per Schedule 5 of Trust's terms of Authorisation)	**22,800**	22,800
TOTAL PRUDENTIAL BORROWING LIMIT	**113,329**	115,100
Long term borrowing at 1 April	**90,529**	92,300
Net actual borrowing/(repayment) in year - long term	**(1,713)**	(1,771)
Long term borrowing at 31 March	**88,816**	90,529
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 £90.5m in 2012/13 (£92.3m in 2011/12) 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 2012/13.

The Trust's approved working capital facility limit was £22.8m in 2012/13 (£22.8m 2011/12). The Trust did not use this facility during the 2012/13 or 2011/12 financial years.

Note 21.2 Financial Ratios

	2012/13		2011/12	
	Actual	Approved	Actual	Approved
Financial Ratios				
Minimum dividend cover	6.2x	5.4x	4.0x	3.6x
Minimum interest cover	3.7x	3.7x	2.3x	2.3x
Minimum debt service cover	3.0x	3.0x	2.0x	2.0x
Maximum debt service to revenue	2.6%	2.7%	3.6%	3.7%

Note 22 Other liabilities

	Sunday, March 31, 2013	Saturday, March 31, 2012
	£000	£000
Current		
Deferred income - goods and services	**628**	1,052
Other Deferred income	**97**	97
TOTAL OTHER CURRENT LIABILITIES	**725**	1,149
Non-current		
Deferred income - goods and services	**10**	1,791
Other deferred income	**1,643**	-
TOTAL OTHER NON CURRENT LIABILITIES	**1,653**	1,791

Note 22.1 Other Financial Liabilities

	Sunday, March 31, 2013	Saturday, March 31, 2012
	£'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	-	-

Note 23 Provisions and contingent liabilities

Note 23.1 Provisions for liabilities and charges

	Current		Non-current	
	Sunday, March 31, 2013	Saturday, March 31, 2012	Sunday, March 31, 2013	Saturday, March 31, 2012
	£000	£000	£000	£000
Pensions relating to other staff	**262**	262	**1,849**	2,058
Other legal claims	**86**	126	**0**	-
Restructurings	**2,516**	-	**-**	-
Redundancy	**414**	-	**-**	-
Other	**2,944**	1,648	**1,054**	1,132
Total	**6,222**	2,036	**2,903**	3,190

Note 23.2 Provisions for liabilities and charges analysis

	Total	Pensions - former directors	Pensions - other staff	Other legal claims	Re-structurings	Redundancy	Other *
	£000	£000	£000	£000	£001	£000	£000
At 1 April 2012	**5,226**	**-**	**2,320**	**126**	**-**	**-**	**2,780**
Arising during the year	**6,238**	-	-	34	2,516	414	3,274
Utilised during the year	**(762)**	-	(274)	(61)	-	-	(427)
Reversed unused	**(1,675)**	-	-	(13)	-	-	(1,663)
Unwinding of discount	**99**	-	65	-	-	-	34
At March 2013	**9,125**	**-**	**2,111**	**86**	**2,516**	**414**	**3,998**
Expected timing of cashf ows:							
- not later than one year;	**6,222**	-	262	86	2,516	414	2,944
- later than one year and not later than five years;	**1,226**	-	968	-	-	-	258
- later than five years.	**1,677**	-	881	0	-	-	796
TOTAL	**9,125**	**-**	**2,111**	**86**	**2,516**	**414**	**3,998**

*The significant values within Other Provisions of £3.997m relate to provisions of £1.1m for Injury Benefit payments for previous employees of the Trust payable to NHS Pensions Agency and £1.6m relating to the closed St Lukes site. All other provisions are individually less than £1m.

Note 23.3 Clinical Negligence liabilities

	Sunday, March 31, 2013	Saturday, March 31, 2012
	£000	£000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Calderdale and Huddersfield NHS Foundation Trust.	56,836	50,948

Note 23.4 Contingent (Liabilities) / Assets

There were no contingent liabilities or assets to disclose at 31 March 2013 or 31 March 2012.

Note 24 Related Party Transactions

The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24.

Monitor have directed, through the Annual Reporting Manual 2012/13, that all bodies within the scope of 'Whole of Government Accounts' (WGA) are related parties. Accordingly, the table below details material transactions.

Related party transactions - WGA organisations	**2012/13**	**2011/12**
	£000	**£000**
Income - NHS Calderdale	**153,894**	147,888
Income - NHS Kirklees	**146,645**	143,836
Income - NHS Bradford & Airedale	**8,672**	8,263
Income - NHS Wakefield District	**2,557**	3,117
Income - South West Yorkshire Partnership NHS Foundation Trust	**4,765**	4,181
Income - Yorkshire & Humber SHA	**9,481**	9,140
Income - NHS Litigation Authority	**-**	5
Income - Other WGA	**16,087**	12,636
Income - Total with WGA organisations	**342,101**	329,066
Expenditure - NHS Calderdale	**803**	982
Expenditure - NHS Kirklees	**379**	280
Expenditure - NHS Bradford & Airedale	**10**	44
Expenditure - NHS Wakefield District	**-**	78
Expenditure - South West Yorkshire Partnership NHS Foundation Trust	**406**	130
Expenditure - Yorkshire & Humber SHA	**23**	27
Expenditure - NHS Pension Scheme	**20,669**	21,042
Expenditure - NHS Litigation Authority	**7,513**	7,202
Expenditure - National Insurance Fund	**12,668**	12,819
Expenditure - Other WGA	**7,465**	7,642
Expenditure - Total with WGA organisations	**49,936**	50,246
Related party balances - WGA organisations	**31 March 2012**	**31 March 2012**
	£000	**£000**
Receivables - NHS Calderdale	**2,473**	1,812
Receivables - NHS Kirklees	**1,438**	1,825
Receivables - NHS Bradford & Airedale	**37**	377
Receivables - NHS Wakefield District	**3**	301
Receivables - South West Yorkshire Partnership NHS Foundation Trust	**315**	722
Receivables - Yorkshire & Humber SHA	**113**	69
Receivables - NHS Litigation Authority	**-**	5
Receivables - Other WGA	**3,387**	1,763
Receivables - Total with WGA organisations	**7,766**	6,874
Payables - NHS Calderdale	**1**	464
Payables - NHS Kirklees	**28**	56
Payables - NHS Bradford & Airedale	**-**	25
Payables - NHS Wakefield District	**-**	80
Payables - South West Yorkshire Partnership NHS Foundation Trust	**136**	122
Payables - Yorkshire & Humber SHA	**-**	449
Payables - NHS Pension Scheme	**2,743**	2,702
Payables - NHS Litigation Authority	**-**	1
Payables - HMRC - Taxes & Duties	**2,180**	2,331
Payables - National Insurance Fund	**1,991**	2,003
Payables - Other WGA	**1,123**	2,677
Payables - Total with WGA organisations	**8,202**	10,910

Note 24 Related Party Transactions

In 2011/12 Under International Accounting Standard 27, the Trust was viewed as having 'control' over Woodstock Management Company (Huddersfield) Limited. The Trust owned five of 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 did not hold any title to any of the Woodstock properties. It had a net asset balance of nil and the value of transactions anticipated in a year were normally less than £1,000 (which involved costs being incurred which were then recouped from shareholders). The Trust owned five of the nine shares of the Company and two of the three Woodstock Management Company directors were Directors of the Trust (and were appointed as such by the Board of Directors of the Trust). As of September 2012 the Trust no longer owned any of the Woodstock Properties, and as a result the Trust no longer held any shares in the Woodstock Management Company, at which point the Trust's two Directors resigned as Directors of the Woodstock Management Company.

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 and Huddersfield NHS Foundation Trust Charitable Fund	2012/13	2011/12
	£000	£000
Income	410	623
Expenditure	-	-
Related party balances - Calderdale and Huddersfield NHS Foundation Trust Charitable Fund	**31 March 2013**	**31 March 2012**
	£000	£000
Receivables	23	76
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 5).

Note 25.1 Joint Venture

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This newly created partnership is the Pennine Property Partnership LLP and is owned 50/50 by the Trust and Henry Boot Development Ltd. It will develop a new 56,000 sq ft healthcare facility following the exchange of a pre-let agreement, with the Trust to operate the building.
The development will involve the substantial reconstruction and refurbishment of an existing derelict stone mill, known as Acre Mill, and will provide a range of modern outpatient facilities.
The Pennine Property Partnership LLP's principal place of business is within the UK.
The Trust has used the equity accounting method.
There are no contingent liabilities of the JV for which the Trust is jointly and contingently liable.
The JV has no capital commitments.

Disclosure of aggregate amounts for assets and liabilities of jointly controlled operations	Sunday, March 31, 2013	Saturday, March 31, 2012
	£000	£000
Current assets	**-**	-
Non current assets	**916**	322
Total assets	**916**	322
Current liabilities	**(916)**	(322)
Non current liabilities	**-**	-
Total liabilities	**(916)**	(322)
Operating income	**-**	-
Operating expenses	**-**	-
Surplus /(deficit) for the year	**-**	-

Note 26 Contractual Capital Commitments

	Sunday, March 31, 2013	Saturday, March 31, 2012
	£000	£000
Property, Plant and Equipment	**438**	325
Intangible assets	**-**	186
Total	**438**	511

Note 26.1 Other Financial Commitments

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

Note 26.2 Finance lease obligations

	Sunday, March 31, 2013	Saturday, March 31, 2012
Gross lease liabilities	59	-
of which liabilities are due		
- not later than one year;	34	-
- later than one year and not later than five years;	25	-
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	59	-
- not later than one year;	34	-
- later than one year and not later than five years;	25	-
- later than five years.	-	-

All Finance Lease obligations are for Plant & Machinery.

Note 27 PFI (on Statement of Financial Position)

Note 27.1 PFI obligations (on Statement of Financial Position)

		Restated*	Original
	Sunday, March 31, 2013	Saturday, March 31, 2012	Saturday, March 31, 2012
	£000	£000	£000
Gross PFI liabilities	**312,216**	318,981	253,805
of which liabilities are due			
- not later than one year;	**11,907**	11,497	11,271
- later than one year and not later than five years;	**49,111**	47,867	44,662
- later than five years.	**251,198**	259,617	197,872
Finance charges allocated to future periods	**(229,090)**	(234,646)	(169,470)
Net PFI obligation	**83,126**	84,335	84,335
- not later than one year;	**1,312**	1,209	1,209
- later than one year and not later than five years;	**5,806**	5,636	5,636
- later than five years.	**76,008**	77,490	77,490

Note 27.2 On-SoFP PFI commitments in respect of the service element of the PFI

		Restated*	Original
	Sunday, March 31, 2013	Saturday, March 31, 2012	Saturday, March 31, 2012
	£000	£000	£000
Commitments			
Within one year	**10,541**	10,167	9,967
2nd to 5th years (inclusive)	**44,317**	42,741	39,869
later than five years.	**173,368**	181,771	141,202
	228,226	234,679	191,038

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

* Gross PFI Liabilities and On-SoFP PFI commitments for 2012/13 includes inflation of 2%. To aid year on year comparison the 2011/12 figures have been restated to include inflation of 2%.

Note 28 For PFI schemes deemed to be off-Statement of Financial Position

The Trust has no PFI Schemes deemed to be off-Statement of Financial Position.

Note 29 Financial assets and financial liabilities

Note 29.1 Financial assets by category

	Total
	£000
Assets as per Statement of Financial Position	
NHS Trade and other receivables excluding non financial assets (at 31 March 2013)	**6,904**
Non-NHS Trade and other receivables excluding non financial assets (at 31 March 2013)	**186**
Cash and cash equivalents (at bank and in hand at 31 March 2013)	**33,407**
Total at 31 March 2013	**40,497**
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 March 2012)	20,306
Total at 31 March 2012	27,092

All financial assets at 31 March 2013 and 31 March 2012 were classified as loans and receivables. The Trust had no financial assets held at fair value through Income and expenditure, Held to maturity or Available-for-sale.

Note 29.2 Financial liabilities by category

	Total
	£000
Liabilities as per Statement of Financial Position	
Borrowings excluding Finance lease and PFI liabilities	**5,632**
Obligations under finance leases (at 31 March 2013)	**59**
Obligations under Private Finance Initiative contracts	**83,126**
NHS Trade and other payables excluding non financial assets	**1,119**
Non-NHS Trade and other payables excluding non financial assets	**28,922**
Other financial liabilities	**-**
Total at 31 March 2013	**118,858**
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

All financial liabilities at 31 March 2013 and 31 March 2012 were classed as other financial liabilities. The Trust had no liabilities held at fair value through income and expenditure.

Note 29.3 Maturity of Financial liabilities

	31 March 2013	31 March 2012
	£000	£000
In one year or less	**31,950**	23,944
In more than one year but not more than two years	**2,010**	1,874
In more than two years but not more than five years	**6,071**	6,012
In more than five years	**78,827**	80,872
Total	**118,858**	112,702

Note 29.4 Fair values of financial assets at 31 March 2013

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

Note 29.5 Fair values of financial liabilities at 31 March 2012

	Book Value £000	Fair value £000
Non current trade and other payables excluding non financial liabilities	**-**	**-**
Provisions under contract	**-**	-
Loans	**5,632**	5,632
Other	**-**	-
Total	**5,632**	5,632

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

Note 29.6 Financial Instruments

Financial risk management
Because of the continuing service provider relationship that the NHS Foundation Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust neither buys or sells financial instruments. The NHS Foundation Trust has limited powers or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Board of Directors has approved a Treasury Management policy which sets out the parameters for investing any surplus operating cash in short-term deposits. This includes the restriction of any such investment to permitted institutions with appropriate credit ratings; these ratings are in line with the guidance issued by Monitor 'Managing Operating Cash in NHS Foundation Trusts'. In addition the policy sets out the maximum limits for any such investments. The policy, and its implementation are reviewed by the Audit & Risk Committee and the Board of Directors. The Trust's treasury management activity is subject to review by the Trust's internal auditors.

Interest rate risk
All of the Trust's financial liabilities carry nil or fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

Liquidity risk
The Trust's operating costs are largely incurred under contracts with local 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 2012/13 the Trust has financed it's 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.

Note 30 Health Informatics

The Trust provides information management and technology services to a number of other NHS Organisations from the Health Informatics Service. The income and expenditure of the service are included in the Statement of Comprehensive Income; and the value of income in 2012/13 was £7,763,035 (£7,829,000 in 2011/12).

Note 31 Limitation on Auditors Liability

There is £1m limit on our external Auditors liability.

Note 32 Losses and special payments

Note 32.1 Losses and special payments
There were 42 cases of losses and special payments totalling £76,000 during the period covered by these accounts (69 cases totalling £173,000 in 2011/12).

There were no clinical negligence cases where the net payment exceeded £100,000.

There were no fraud cases where the net payment exceeded £100,000.

There were no personal injury cases where the net payment exceeded £100,000.

There were no compensation under legal obligation cases where the net payment exceeded £100,000.

There were no fruitless payment cases where the net payment exceeded £100,000.

Note 32.2 Recovered Losses
The Trust has not received any compensation payments from CHCC.

Note 33 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012/13. The application of the Standards as revised would not have a material impact on the accounts for 2012/13, were they applied in that year:

IFRS 9 Financial Instruments
Financial Assets:
Financial Liabilities:
IFRS 10 Consolidated Financial Statements
IFRS 11 Joint Arrangements
IFRS 12 Disclosure of Interests in Other Entities
IFRS 13 Fair Value Measurement
IAS 12 Income Taxes amendment
IAS 1 Presentation of financial statements, on other comprehensive income (OCI)
IAS 27 Separate Financial Statements
IAS 28 Associates and joint ventures.
IAS 19 (Revised 2011) Employee Benefits
IAS 32 Financial Instruments: Presentation - amendment Offsetting financial assets and liabilities
IFRS 7 Financial Instruments: Disclosures – amendment Offsetting financial assets and liabilities

Calderdale and Huddersfield NHS

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