NHS

Calderdale and Huddersfield

NHS Foundation Trust

Annual Report and Accounts 2017/18

compassionate care

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts

2017/18

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

Contents

Cover picture

Our staff nurses Emily Pawson and Sophie Whiteley on Ward 19 at Huddersfield Royal Infirmary with one of the new Electronic Patient Records trolleys.

Introduction

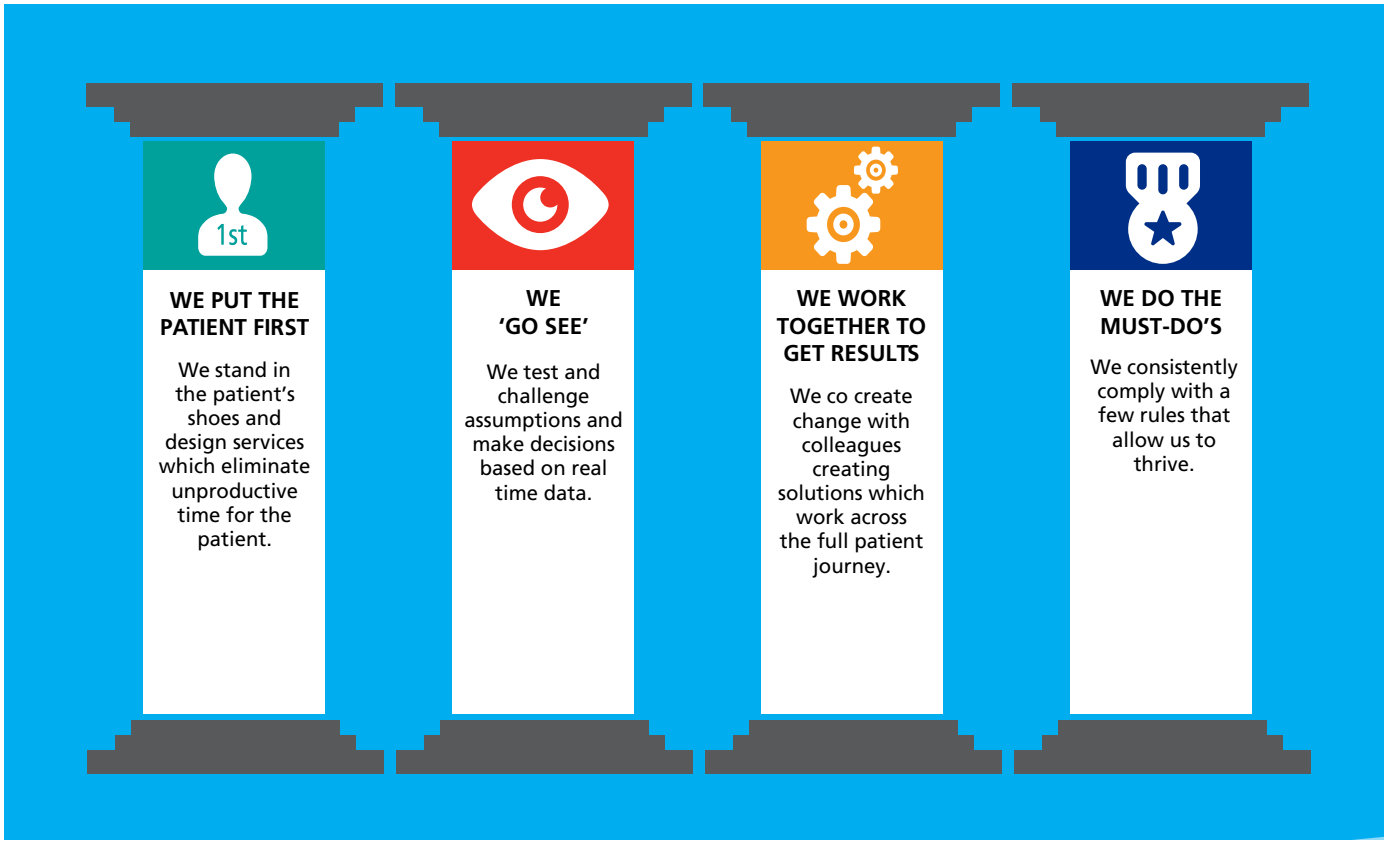
Introduction

Our vision and values

Together we will deliver outstanding compassionate care to the communities we serve

This is supported by the Trust's values, the four pillars of behaviour that it expects all employees to follow and which are embedded into the organisation so that every member of staff understands their responsibilities. These are:

- **We put the patient first**
- **We go see**
- **We work together to get results**
- **We do the must dos**



Chairman's statement

Hello, my name is Philip Lewer and I became chair of Calderdale and Huddersfield NHS Foundation Trust on April 1, 2018.

For me it is an honour and a privilege to be appointed to this post. I am very grateful to Andrew Haigh our outgoing Chairman, for his friendly help, advice and guidance.

I started with Hello My Name Is…. as I believe that little sentence is a very important one for everyone in the NHS. It's a campaign started by the late Dr Kate Granger to make sure every porter, therapist, nurse and doctor – anyone in fact involved in caring introduces themselves to their patients.

I have been very impressed with everyone I have had contact with. The commitment to putting the patient first is something which has had a real impact on me in the short time that I have been here. We are therefore very much aware of how our staff go above and beyond for our patients. For me this was clearly evidenced by the commitment of staff during the winter snow. There is a tremendous culture here of putting the patient first and working together.

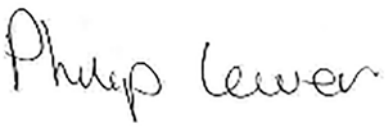
The staff I have met have shown real pride in the service and care we offer. Our staff talk about 'we' and not 'I' here at the Trust. Every month we recognise them through our Star Award Scheme. They are nominated by their colleagues on the front line, which makes it extra special. We are now into the third year of the Awards, entries continue to increase and nominations come from every role we have at the Trust: doctors, nurses, therapists, midwives, porters and administrators.

We face many challenges within the NHS nationally, during the coming year. I also want to recognise the enthusiasm and commitment of our volunteers who freely give us their time to make a real difference to our patients.

I very much look forward to my first year here at Calderdale and Huddersfield NHS Foundation Trust, working alongside my colleagues, our Governors and Volunteers, building on our strengths, traditions and culture of enthusiasm, openness, honesty and putting the patient first.

I know I have many people to meet in so many roles and all committed to caring for our patients … and that is very exciting.

Regards



Philip Lewer, Chair


Stop
Gel
Go

Performance Report

Overview of performance

Statement from the Chief Executive

I am going to start by hailing the past 12 months as the year of Compassionate Care.

And here I shall tell you why.

As you know our Trust places great store on our Four Pillars of behaviour which are; we put the patent first; we go see; we do the must dos and we work together to get results.

In some respects, the words are easy but putting them into practice every single day and night is something else altogether. Whether you work in one of our hospitals or in our numerous community locations it is our collective belief in providing Compassionate Care underpinned by the application of our Four Pillars that binds us together and makes the difference for the local people we serve.

And, by working together through some of the toughest times ever, our fellow CHFT colleagues and volunteers have truly produced a year which has featured compassion not just for our patients but from one colleague to the other.

Despite the financial challenges and the "big bang" introduction of electronic patient records (EPR) here at the Trust in May 2017, we have never consciously waivered, or compromised, or taken our eye off the ball and let our standards fall.

It's been even better than that. We have been top of the league for delivery of the three core NHS Constitutional patient targets: referral to treatment times, the emergency care standard of waiting four hours or less in A&E and cancer referral times. How a Trust performs against them shows its true colours and, I am pleased to say, when all the scores were in and added up we find ourselves, for the last two years combined, on top of the table of Trusts from all over the country.

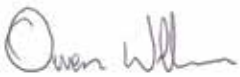
As well as the high performance against these three targets we also worked hard to improve care in other areas which are important to us. For example, we have seen our mortality rates fall, our service performance for patients with a fractured neck of femur has improved and we have halved the number of still-births.

We also had an NHS England led external assessment of the impact of the implementation of our EPR. While that has not been without its many challenges, we have achieved an improvement in our position nationally in the digital maturity index to joint 3rd against 41 national groupings. This was considered an exceptional performance and has been described as a positive 'case study' by Deloitte who conducted the assessment on behalf of NHS England.

In April this year the Care Quality Commission undertook a new Well Led and Core Service inspection of the care we provide as a part of what is now called the Single Operating Framework. The report will be published in June so it is a fraction too early to share our latest rating but colleagues across the Trust were able to demonstrate high quality patient care and improvement in a number of service areas.

There still remains much to do. Our financial position presents us with ongoing challenges. The recent report from the Independent Reconfiguration Panel requires us to do some further work on out of hospital care; hospital capacity; and capital funding. We will crack on with this together with our local people; CHFT colleagues; our regulators; clinical commissioners and scrutiny.

So, in conclusion, much to look forward to, and much work ahead. May our commitment to providing Compassionate Care at CHFT and with our partners continue to deliver for our patients and their families.



Owen Williams

Our purpose and activities

The principal purpose of the Trust is the provision of goods and services for the purpose of health care in England. The principal location of business of the Trust is:
Trust Headquarters, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, West Yorkshire HD3 3EA

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

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

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

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

Calderdale and Huddersfield NHS Foundation Trust is an integrated trust. It provides acute and community health services. The trust serves two populations; Greater Huddersfield which has a population of 248,000 people and Calderdale with a population of 205,300 people. The trust operates acute services from two main hospitals; Calderdale Royal Hospital and Huddersfield Royal Infirmary. The trust has approximately 800 beds and 6,000 staff.

We provide a range of services including urgent and emergency care; medical; surgical; maternity; gynaecology; critical care; children's and young people's services; end of life care and outpatient and diagnostic imaging services.

We provide community health services , including sexual health services in Calderdale from Calderdale Royal and local health centres. These include St Johns Health Centre, Todmorden Health Centre and Broad Street Plaza.

In 2017/18 we cared for more than 116,000 men, women and children as inpatients (stayed at least one night) or day cases.

There were also over 600,000 outpatient attendances; over 150,000 accident and emergency attendances; and almost 5,000 babies delivered. There were some 277,000 adult services contacts by our community teams as well as 236,000 contacts with our therapy services.

Our 6,000 colleagues provide compassionate care from our two main hospitals, the Calderdale Royal Hospital, and the Huddersfield Royal Infirmary, as well as in our community sites, health centres and in our patients' homes.

A brief history

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

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

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

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.

In 2006 maternity and surgical services were reconfigured to provide obstetric maternity care and most children's inpatient services on the Calderdale site and trauma surgery on the Huddersfield site. Stroke care was also centralised on the Calderdale site.

In 2015 we opened our state of the art outpatients centre in Acre Mills in Lindley, Huddersfield. We also won the tender to provide sexual health services in Calderdale in a joint bid with the Calderdale GP Federation. We continue to work with partners in both Calderdale and Huddersfield to develop and deliver high quality, compassionate health care services for our patients.

During 2017 medical services were reconfigured in response to recommendations from the Royal College of Physicians (RCP) Invited Service Review (ISR) for Elderly Care Services and Respiratory Medicine. The reports gave a strong recommendation that improvements could be made through centralising the services into a single site model.

"Overall, the review team were firmly of the opinion that the respiratory team would benefit from having inpatient services located on one site as they considered this would improve cover arrangements of patients (particularly at weekends), would facilitate a sharing of skill sets and a move to 7-day service" (Respiratory ISR) "The review team did consider the Trust should give serious consideration as to whether the CoE services are able to move to one site sooner than presently planned" (Care of the Elderly ISR)

As a result, in November 2017 cardiology and respiratory services were co-located at Calderdale Royal Hospital and all elderly medical services were moved to Huddersfield Royal Infirmary alongside a new frailty service on both sites.

Key issues and risks

The Trust continued to strengthen its risk management processes during 2017/18 with a review of the divisional risk management arrangements and the risk management strategy. The risk appetite statement will be refreshed in May 2018. An internal audit of divisional governance received significant assurance.

There is a regular review of the Board Assurance Framework and the high level risk register at the Board and its sub-committees. A description of the principle risks and uncertainties facing the Trust is set out in the Annual Governance Statement on p94.

In May 2017, the Board of Directors agreed the annual plan – setting out its key areas of delivery for year two of the five year plan. The plan aims to achieve the Trust vision of 'Together we will deliver outstanding compassionate care to the communities we serve' and is built around the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

The risks to the achievement of the goals are described in the Board Assurance Framework as:
Transforming and improving patient care

- Risk that the Trust will not secure agreement to implement the proposals set out in the Full Business Case resulting in poor quality of care and impacting on workforce resilience.
- Risk of non-delivery of the West Yorkshire Association of Acute Trusts programme as part of the wider West Yorkshire Sustainability and Transformation Partnership due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'.
- Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.
- Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions
- Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's electronic patient record due to lack of optimisation of the system.

Keeping the base safe

- Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.
- Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action
- Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.
- Risk of failure to maintain current estate and equipment and to develop future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.

A workforce fit for the future

- Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
- Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future
- Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms

Financial sustainability

- Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention
- Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.

The management and mitigation of these risks is reported to the Board each month. More information on the Trust's risk management arrangements is included in the Annual Governance Statement on p94.

Additional challenges

In May 2017 the Trust implemented an electronic patient record (EPR) across the whole organisation, in partnership with Bradford Teaching Hospitals NHS Foundation Trust (BTHFT). Over 80% of Trust staff were trained prior to go live and 100% of standard operating procedures were written and signed off. As would be expected with a change programme of this size, the implementation has led to a number of challenges relating to GP letters; reporting of information; patient flow and an impact on activity. There is a specific governance structure in place to manage risks relating to the function and use of EPR. Each division has a digital board which reports to the trust wide operational group. Risks are also considered for inclusion on the High Level Risk Register in the normal way through the Risk and Compliance Group.

Proposals to reconfigure hospital services are the subject of a Judicial Review and scrutiny by the Secretary of State for Health and Social Care. More on this is included on p27.

At its meeting on 1 March 2018 the Board of Directors approved the establishment of a wholly owned subsidiary to provide estates, facilities and procurement. The Company will begin operating on 1 September 2018 as Calderdale and Huddersfield Solutions Ltd and work is underway to ensure that it is appropriately established in advance of that date. The Company will employ around 400 staff and will be led by a small management team. There has been ongoing engagement with all affected staff over the last 12 months and this will continue alongside formal consultation beyond the operational date of the company.

Financial sustainability

The Trust continues to operate in a difficult financial environment being shaped by the national financial picture with the on-going need to reduce the public deficit and bring NHS finances at a national level back into balance. This sits alongside the continued challenges of ensuring safe staffing levels in the context of shortages in the available clinical workforce; delivering year on year efficiency savings; investing in developing technology and maintaining facilities; and responding to increasing demand and seasonal pressures.

The Trust has used its 2017/18 financial performance to shape the plan for 2018/19 alongside detailed service demand and capacity modelling and is planning for the following income and expenditure position:

- Underlying deficit of £61.1m;
- Cost improvement programme savings delivery at £18m. This is above the nationally required level, recognising the need to cover specific financial pressures and contain the Trust's deficit;
- Planned deficit position of £43.1m after achievement of efficiencies.

The Trust is also planning to continue to invest in transformational capital technology and essential estate schemes in 2018/19. The total capital expenditure being planned is £9.0m.

As described above, the Trust is reliant upon external cash support in order to continue to operate. The total borrowing requirement in 2018/19 will be £43.8m to cover the day to day running of services as represented by the revenue position and the capital investment programme. Of this £0.7m is being funded by way of an interest free government backed Salix loan available to support investment in energy efficiency projects. The remaining £43.1m is to be secured through further ITFF borrowing.

The plan is mindful of the work in support of the West Yorkshire and Harrogate Sustainability and Transformation Partnership and West Yorkshire Association of Acute Trusts collaborative. New models of service delivery working with partners will be developed to deliver sustainable services in the future. This sits alongside the Trust's own plans for service reconfiguration which aim to support CHFT's strategic objectives, delivering benefits for patients, staff, the Trust and the local health economy.

Going Concern

The accounting concept of Going Concern refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. If an organisation is a going concern, it is expected to operate indefinitely and not go out of business or liquidate its assets in the foreseeable future.

Under International Financial Reporting Standards, management are required to assess, as part of the accounts process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of services to another entity, or has no realistic alternative but to do so.

The Trust Board has assessed various sources of information in order to determine whether it is appropriate to prepare the accounts on a going concern basis. These include both internal and external reporting, the Trust's long term financial plan, audit reports and dialogue with NHS Improvement. The Trust has closed the year with a cash balance of £2.0m and positive net assets of £40.8m. However, given the deficit position and the challenge within the financial plans for 2018/19 further areas require consideration to be able to demonstrate that the Trust is a going concern.

The following has been taken into account when going concern is considered:

- The year-end financial position of £29.9m deficit (excluding impairments as described in note to the SOCI) was in line with the deficit discussed and agreed with the regulator in year. Whilst still a deficit position; this secures a level of confidence from NHS Improvement in the Trust's financial management.
- The Trust is supported by loan funding from the Department of Health and Social Care with a balance totalling £103.9m at 31 March 2018.
- The Trust closed the year with £2.0m of cash but cannot sustain the planned deficit position within 2018/19 without the requirements of external cash support. As such, the Trust has been in communication with NHS Improvement to arrange for loan facilities to enable the Trust to operate throughout 2018/19. Approval and drawdown of this cash funding from the

Department of Health and Social Care will take place on a rolling monthly basis. With this borrowing in place, the Trust will be able to meet its liabilities.

- The Commissioners continue to commission services from the Trust and contracts with commissioners have been agreed and were signed in April 2018. This leads to regular monthly transfers of fixed levels of cash based on contracted values for 2018/19. This incoming cash along with the loan facility will allow the Trust to meet all its obligations and liabilities.
- From Internal Audit reports completed in 2017/18 there have been no other indications of significant financial risk or weaknesses in financial risk management.
- The Trust is continuing to work upon a service transformation strategy working closely with local partners, aided by reconfiguration, to deliver a sustainable long term future. This strategy has been supported by regulators.
- In 2017/18 a cost improvement programme (CIP) of £17.9m was delivered. A project management office is in place which ensures that the CIP plans for 2018/19 are robust and oversees their delivery. The programme methodology is built around a gateway approach for project design, development and delivery that includes a rigorous quality and equality impact assessment review. Delivery of the 2018/19 planned deficit position requires an efficiency saving of a further £18m.

The matters, referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate

However, there is a reasonable expectation that Calderdale and Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

How we measure performance

Like all Trusts, Calderdale and Huddersfield NHS Foundation Trust is under enormous pressure to meet the health care needs of a growing and diverse population, alongside great changes to the infrastructure of the NHS and a difficult financial climate.

The Trust's performance against a range of national targets and standards is assessed and reported externally. These measures include the 4-hour emergency care standard; cancer referral targets; infection control standards; 18-week waiting times and staffing levels.

The Board considers an Integrated Performance Report at each meeting which describes performance against these targets and any action being taken to address dips in performance. This is informed by detailed review at a divisional and executive level prior to the Board meeting.

There is also detailed scrutiny of the different elements of the Integrated Performance Report through the Board sub-committees - Finance and Performance Committee, Quality Committee and the Workforce Well-Led Committee. Each quarter the Board confirms the position of each of these metrics to NHS Improvement. Details of the Trust's performance during the year can be seen below.

The Board also considers a quarterly update on progress against the key strategic objectives identified in the Trust's One Year plan.

Our performance

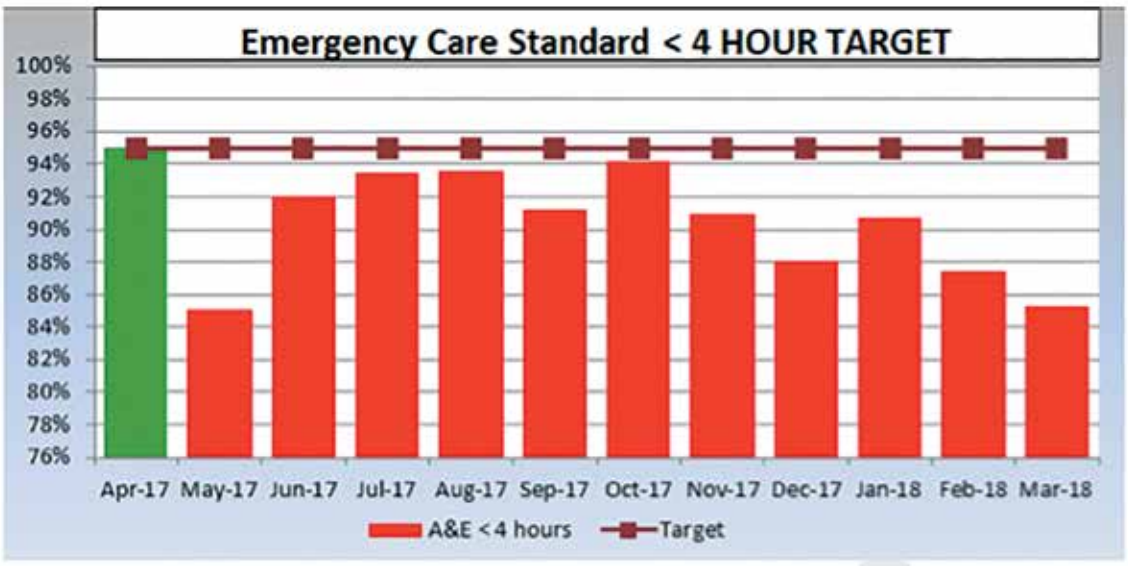
The Trust has continued to deliver a strong performance across all its targets for 2017/18 in the face of significant challenges. The Trust provided safe, compassionate care for all of its patients with a high level of patient satisfaction while continuing to achieve the demanding efficiency savings.

Indicator	Target	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
Total time in ED under 4hrs	95%	90.62%	92.75%	91.09%	89.15%
Referral to Treatment Time, 18 wks. in aggregate, Incomplete pathways	92%	92.58%	92.42%	92.61%	93.75%
Cancer 2 week wait (all)	93%	88.54%	93.90%	96.90%	97.41%
Cancer 2 week wait Breast Symptomatic	93%	92.08%	92.00%	95.20%	96.10%
Cancer 31 days from diagnosis to first treatment	96%	100.00%	99.58%	100.00%	100.00%
Cancer 31 days for second or subsequent treatment – surgery	94%	98.39%	100.00%	98.46%	100.00%
Cancer 31 days for second or subsequent treatment – drug treatment	98%	100.00%	100.00%	100.00%	100.00%
Cancer 62 day wait for first treatment (urgent GP)	85%	88.43%	88.77%	87.16%	90.41%
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	90%	95.24%	89.80%	100.00%	94.59%

A surge in Cancer 2 week referrals early in Quarter 1 impacted on the delivery of this target and the 62 day target in quarter 2.

Like many other trusts, CHFT has had significant challenges in the Emergency Care Standard 4 hours with performance for 2017/18 at 90.6%.

High attendance rates and significant daily variations in demand for non-elective services were a challenge throughout the year.



The health and social care system was busy throughout the winter period with acuity increasing. CHFT was faced with an unprecedented surge in demand for non-elective care in December and January which required the Trust to operate fully in silver command and control mode with an OPEL 3 status for both sites. This continued throughout quarter 4. Winter pressures, flu season, staff shortages and norovirus all impacted on the Trust's resilience and ability to support the flow of patients through the hospital.

CHFT sees 96% of its A&E patients in a Type 1 A&E department (AED) i.e. a consultant led 24 hour service with full resuscitation facilities and designated accommodation for the reception of accident and emergency patients. This percentage is high when compared to some other organisations that also have high numbers in Type 2 (single specialty unit) and Type 3 (walk-in centres and minor injury units). As a result it is important to note the following points:

- There is certainly a higher risk of admissions with a higher volume of attendances and there is national evidence to suggest higher admission rates when AEDs are under pressure. This means we are at greater risk of increased admissions as a high Type 1 provider and this has been the case during 2017/18.
- There is the further risk of increased length of stay (LOS) and discharge delays etc.
- From and AED performance front whilst high volumes give a higher breach tolerance profile, this can itself lead to inefficiencies and waits as well as distorting clinical prioritisation as all attendances have to be seen within the 4 hour window.

There were only 3 organisations nationally with a similar number of Type 1 attendances that performed better than CHFT in 2017/18.

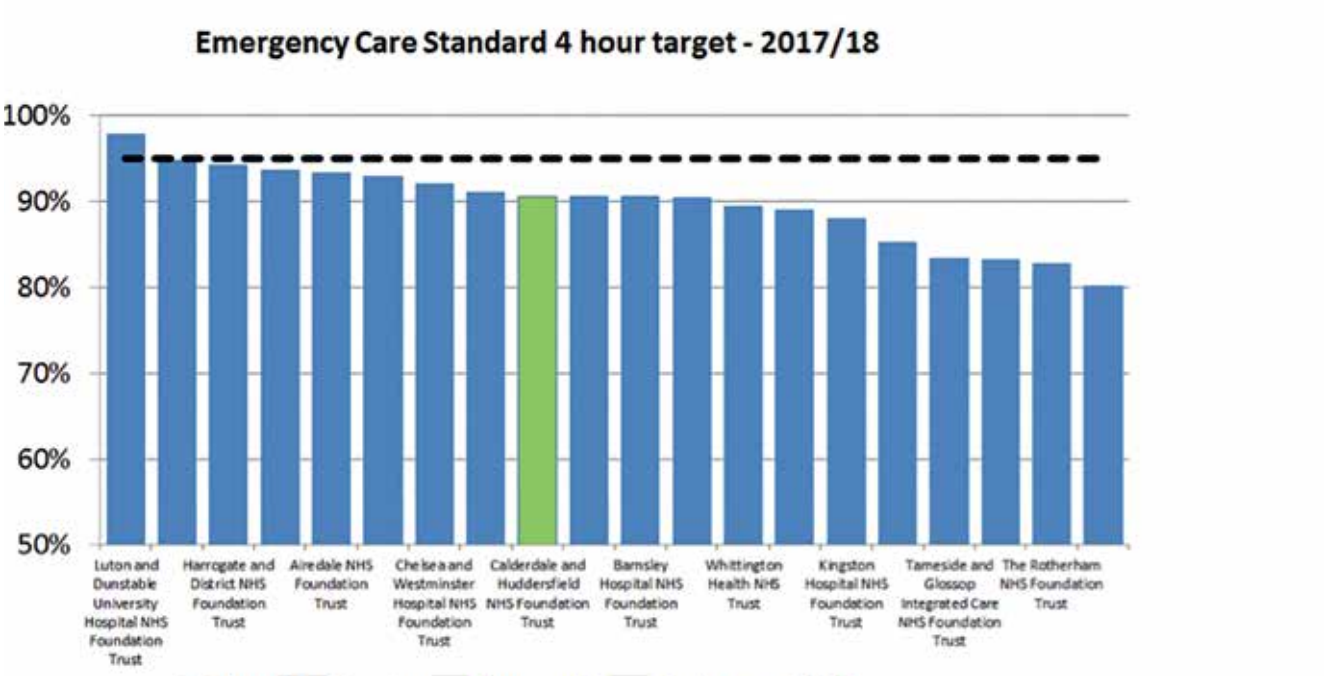
Benchmarking performance

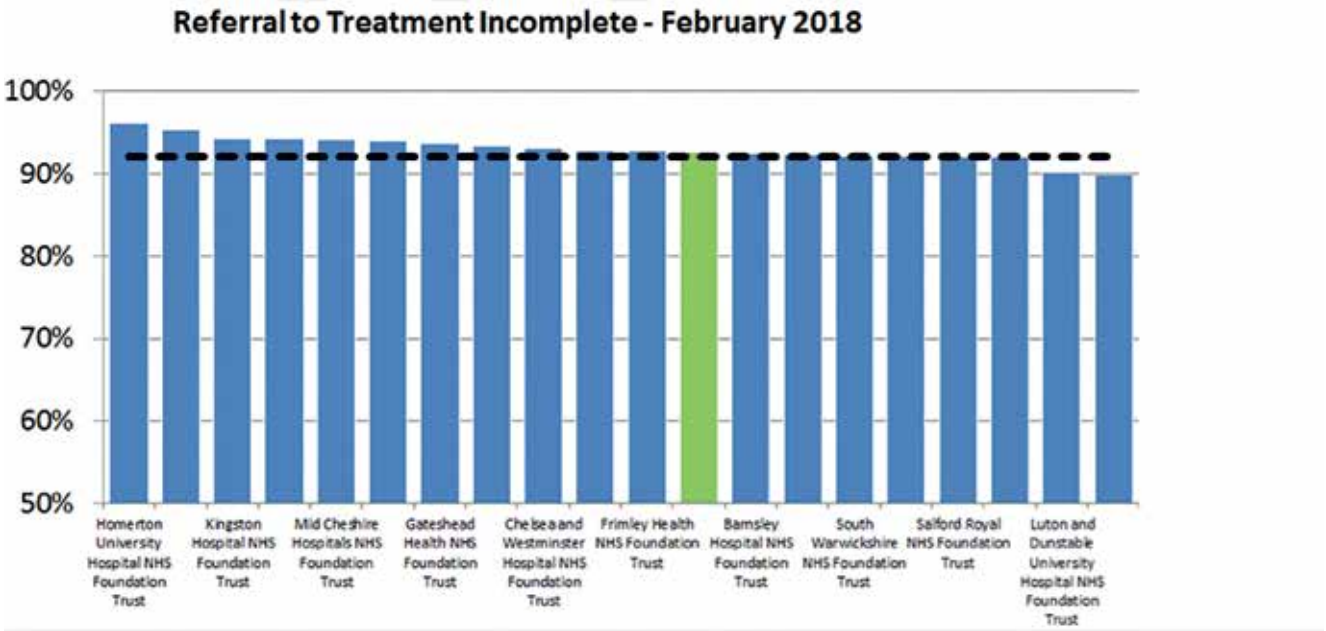
Although the Trust missed the Emergency Care 4-hour standard during 2017/18 and struggled in the first half of the year with its Cancer targets it has benchmarked well nationally over the last 2 years when all 3 key metrics (Emergency Care, 18 weeks Referral to Treatment and 62 day Cancer) are considered together.

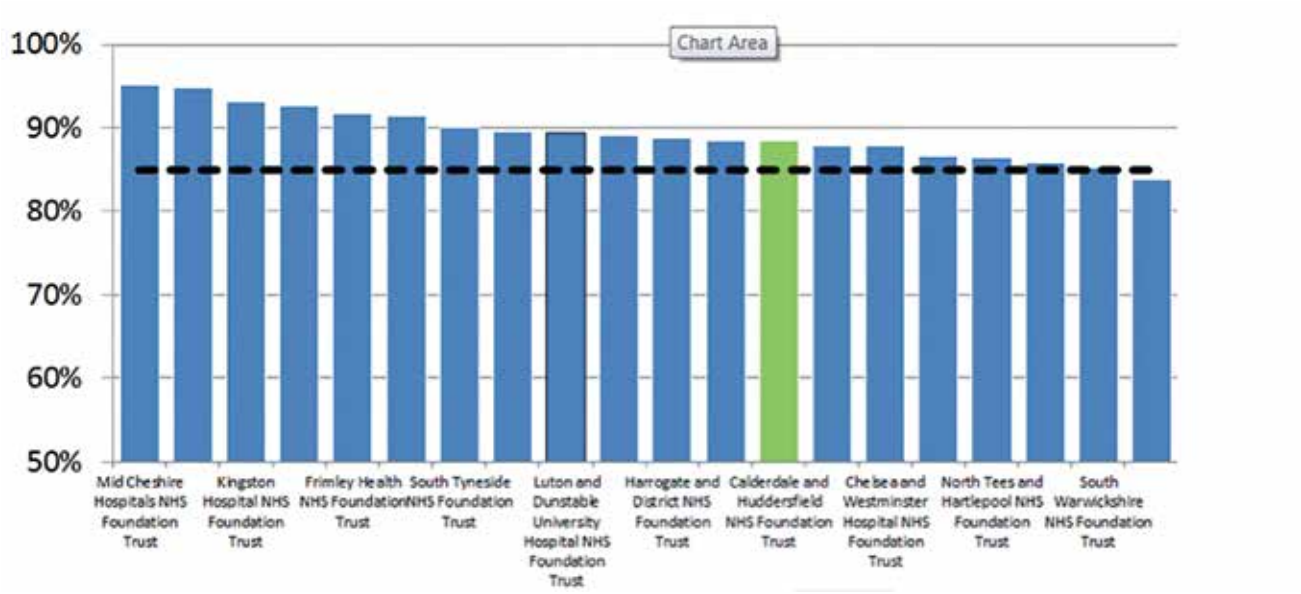
2016/17 1st out of 125 acute organisations
2017/18 7th out of 125 acute organisations

2016-2018 combined CHFT ranks 1st.

The following graphs show how CHFT's 2017/18 performance compared to the top 20 organisations ranked within this 2 year period.







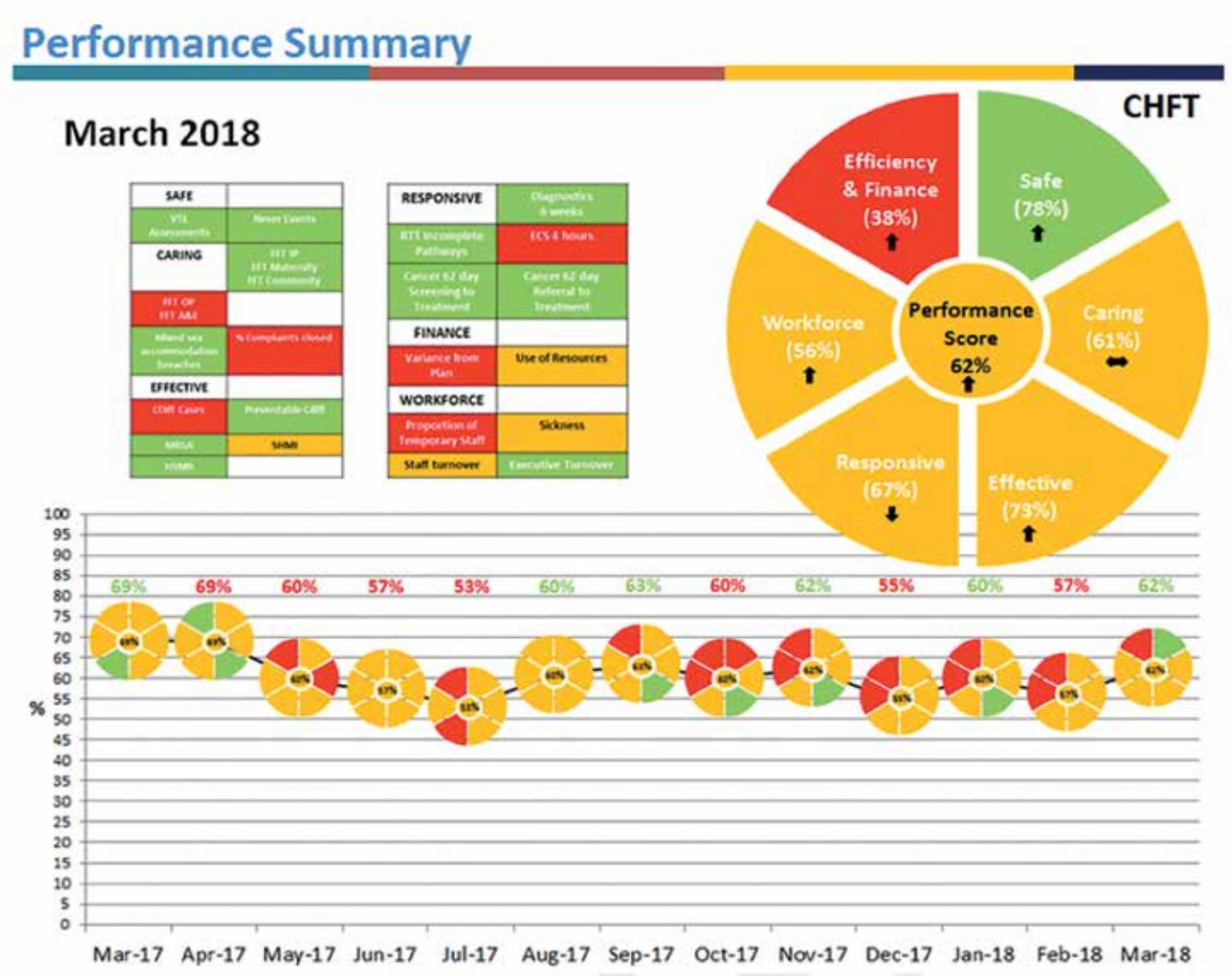
Performance Management Framework

The Trust's Integrated Performance Report (IPR) consists of a performance summary and exception reporting where adverse performance is observed. The report is presented with variances, trends over the last 13 months and benchmarking information to illustrate areas of good and adverse performance. NHS Improvement's Single Oversight Framework (SOF) is one key source of performance measures but also included are key metrics which the Trust would like to focus on derived from the Trust's strategy and operational priorities.

The IPR supports the work of various board committees. The Quality domains are the focus of the Quality Committee, the Workforce Domains the focus of the Workforce and Well-led Committee and the Responsive, Finance and Efficiency domains are reported into Finance and Performance Committee who also look at the overarching performance position.

In addition, Divisional IPRs are also produced in a similar format which also show directorate level with current month and year to date indicators. The production of the Divisional IPRs ensure the timely flow of information, prompt escalation and a golden thread from Ward to Board. Divisions hold Performance Review Meetings with Directorates and in turn the Directors hold a monthly Performance Review Meeting with each Division.

Below is the Performance Summary taken from the March 2018 IPR which shows a split by domain of Trust performance during 2017/18.



Performance against our strategic objectives

In May 2017, the Board of Directors agreed the One Year Plan and quality priorities for 2017/18. The plan described the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

These goals are underpinned by our four behaviours:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The plan set out the key areas of delivery to support the achievement of each of the goals described in the table below. The risks of not delivering the goals were assessed and included in the Board Assurance Framework. The risks associated with each area of delivery were also assessed and included in the corporate risk register.

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Year Ending 2018				
Our Vision	***Together we will deliver outstanding compassionate care to the communities we serve***			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Submit a full business case to NHS Improvement to secure approval of capital funding and agreement to implement	Maintain a Single Oversight Framework rating of 3 or better	Implement the 5 year workforce strategy	Deliver a robust financial plan for 2018 including CIP
		Strengthen patient and public engagement in particular learning from incidents, complaints process, and in listening events	Develop and deliver an organisational development plan	Refresh the commercial strategy in light of current economic climate
	Delivery of 17/18 SAFER (patient flow) programme objectives	Implement the actions resulting from the findings of the CQC inspection in readiness for the new-style inspection.	Create and deliver an engagement strategy that ensures colleagues have a voice	Continue to proactively contribute to WYAAT and the WYSTP.
	To work as an early adopter toward the implementation of selected 7 day NHS England standards (2,5,6 and 8) in agreed specialties	Develop the Quality Strategy and implement the local quality priorities (see separate page)	Develop workforce roles and service models that enable the Trust to deliver care within planned resources and minimise use of agency & temporary staffing	Lead on the development of the IM&T and Estates schemes and progress these to full business case.
	Realise the benefits and transformational change opportunities from the new EPR	Implement year 3 of the health and safety action plan; develop and deliver robust emergency planning and business continuity arrangements	Deliver a leadership and succession planning development programme	Develop a clear plan to meet the organisation's capital requirements
			Deliver a programme of workforce information systems modernisation	compassionate care

The Board received a report on progress against each of these areas on a quarterly basis throughout 2017/18. At the year end, of the 20 deliverables nine had been fully delivered (submission of the Full Business Case; SOF rating of 3; CQC inspection actions; development of a Quality Strategy; year 3 of the Health and Safety plan; financial plan 2017/18; full business case for the estates wholly owned subsidiary; and the 2017/18 capital plan). Eight deliverables were on track but had not been completed by the year end and there were three areas with significant work outstanding. The outstanding areas are:

- Ensuring the benefits and transformational change opportunities from the new EPR are realised;
- Developing an organisational development strategy and plan;
- Creating and delivering a colleague engagement strategy

All of these areas have been carried over as priorities for 2018/19 and progress against the plan will be monitored in the same way.

Care Quality Commission Inspection

The Trust had its first full Care Quality Commission (CQC) Chief Inspector of Hospitals inspection in March 2016 and received an overall rating of 'requires improvement'.

Final ratings for the Trust

	Safe	Effective	Caring	Responsive	Well-led		Overall
Overall	**Requires Improvement**	**Requires Improvement**	**Good**	**Good**	**Requires Improvement**		**Requires Improvement**

The reports from the CQC inspection were published on their website in August 2016 and can be found at the following link: http://www.cqc.org.uk/provider/RWY

The Trust put in place an action plan to address the 19 must do and 12 should do actions detailed in the final report. Some of these impacted on all divisions. Others were specific to a core service and an individual division. All actions were completed in 2017.

In early April 2018 the Trust received its first new style Well Led CQC inspection. This was preceded by unannounced inspections of core services during March as part of their comprehensive inspection programme. In addition the Trust was also one of the first trusts in Yorkshire and the Humber to receive a Use of Resources inspection by NHS Improvement. At the time of writing, the Trust is awaiting feedback and the final report from the CQC.

Sustainability and sustainable development

In 2017/18 the Trust has continued to implement measures to reduce its environmental impact. A sustainable development group, including executive and non-executive directors overseas the sustainable development management plan and associated action plan.

The sustainable development action plan has been revised to be in line with the outcomes that are expected by the NHS Sustainable Development Unit. Key areas of interest for this year have been travel and logistics and the sustainable use of resources.

The local greengrocers stall which is at Huddersfield Royal Infirmary for three days a week has been extended to provide a service at Calderdale Royal Hospital on the other two weekdays, giving a more sustainable option for staff and visitors than pre-packaged supermarket fruit and vegetables.

Links to the wider public health agenda are made through regular meetings with both Kirklees and Calderdale councils; encouraging active travel has been a focus of these meetings in the past year.

Energy usage continues to be a priority for the Trust with the continued roll-out of LED lighting to replace less efficient fluorescent tubes. An ongoing "switch off squad" campaign also encourages staff to take responsibility for their own energy use.

Social and community issues

The Trust has a significant profile in both of the local areas it serves and sees its community role as important both as a health care provider and potential local employer.

The Trust works with a number of local schools and colleges offering work experience and placement opportunities to over 200 students from January to July, with further students attending throughout the autumn term. The Chief Executive and other senior management also participate in the Take Over Day scheme. The Trust continues to support our apprenticeship scheme. As at 31 March 2018, the Trust has 118 apprentices with plans to increase the number and variety of apprenticeship job opportunities further into 2018/19. The Trust is also working towards a year on year increase in staff under the age of 25. The Trust has also formed links with key community and voluntary sector organisations including Calderdale Deaf Society and HealthWatch.

We continued to welcome cohort of sixth form volunteer students on to wards to work with our elderly patients and support our staff delivering dementia care. The students, many of who are hoping to pursue careers in medicine, support staff with a range of activities to stimulate our patients' memories. We also accept requests to come and do work experience within the Trust in a variety of roles and departments.

We have a number of policies in place which cover social, community, counter fraud, bribery and human rights matters. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients or staff.

Important events since the end of the financial year 2017/18

Care Quality Commission Well Led Inspection
During March and April 2018 the Trust received its first full Well Led Care Quality Commission inspection and was also one of the first trusts in Yorkshire and the Humber to receive a Use of Resources inspection by NHS Improvement. As at the time of writing, the Trust has not received feedback or a report from the Care Quality Commission on either the Well Led or the Use of Resources inspections and so the rating of requires improvement is still in place.

Proposed reconfiguration of hospital services – Right Care Right Time Right Place
In July 2017 the Joint Calderdale and Kirklees Overview and Scrutiny Committee (JOSC) referred the proposals regarding the reconfiguration of hospital services to the Secretary of State for Health and Social Care. The Secretary of State asked the Independent Reconfiguration Panel to review the referral. They published their report on 11 May 2018. The Panel found that status quo is not an option and that one site acute care is the right. They also stated that an alternate model to the one proposed had not been found during consultation, therefore pursuing the proposal in more detail is reasonable in the interests of local health services. They set out that further work should be done on three areas: out of hospital care; hospital capacity; and capital funding. The accompanying letter from the Secretary of State asked that commissioners and regulators work with the JOSC and report back in three months.

Overseas operations

The Trust has no overseas operational activity and has received no commercial income from overseas activity during the year.

Signed

Owen Williams
Chief Executive
24 May 2018

Accountability Report

Directors' Report

Composition of the Board of Directors

The members of the Board during 2017/18 were: [insert structure chart]

- Andrew Haigh – Chairman
- Owen Williams – Chief Executive

- Helen Barker – Chief Operating Officer
- Dr David Birkenhead – Executive Medical Director
- Gary Boothby – Executive Director of Finance
- Brendan Brown – Executive Director of Nursing/ Deputy Chief Executive
- Lesley Hill – Executive Director of Planning, Estates and Facilities
- Ian Warren – Executive Director of Workforce and Organisational Development resigned 1.8.17
- Suzanne Dunkley – Executive Director of Workforce and Organisational Development appointed 1.2.18

- Dr David Anderson – Non-Executive Director and Senior Independent Director
- Karen Heaton – Non-Executive Director and Chair of Workforce Well-Led Committee
- Richard Hopkin – Non-Executive Director and Chair of Audit and Risk Committee from 22.9.17
- Phil Oldfield – Non-Executive Director, Deputy Chair and Chair of the Finance and Performance Committee
- Dr Linda Patterson – Non-Executive Director and Chair of the Quality Committee
- Professor Peter Roberts – Non-Executive Director and Chair of the Audit and Risk Committee – tenure ceased on 22.9.17
- Jan Wilson – Non-Executive Director and Deputy Chairman – tenure ceased on 1.12.17
- Andy Nelson – Non-Executive Director – tenure commenced 1.10.17
- Alastair Graham – Non-Executive Director – tenure commenced 1.12.17

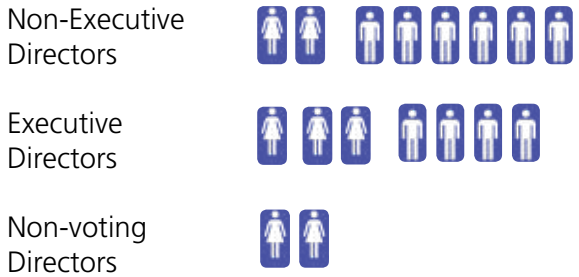
The Board also has two additional non-voting Directors:

- Anna Basford – Director of Transformation and Partnerships
- Mandy Griffin – Managing Director – Digital Health

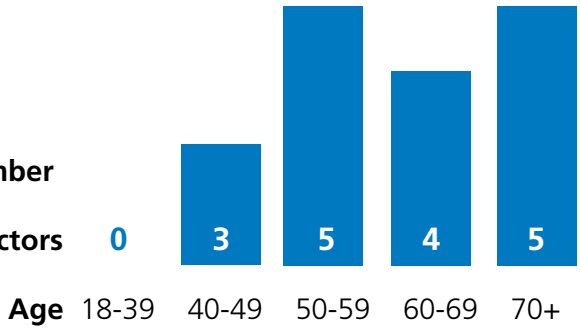
The following changes in the membership of the Board occurred during the year:

- Ian Warren - Executive Director of Workforce and Organisational Development – resigned 1.8.17
- Suzanne Dunkley, Executive Director of Workforce and Organisational Development – appointed 1.2.18
- Prof Peter Roberts - Non-Executive Director and Chair of the Audit and Risk Committee – tenure ceased on 22.9.17
- Jan Wilson – Non-Executive Director and Deputy Chairman – tenure ceased on 1.12.18
- Andy Nelson – Non-Executive Director – tenure commenced 1.10.17
- Alastair Graham – Non-Executive Director – tenure commenced 1.12.17

The gender balance of the Board as at 31 March 2018 was:



The age profile of the Board as at 31 March 2018 was:



Meetings of the Board of Directors

The Board of Directors met 12 times during 2017/18 including the Annual General Meeting.

NAME OF DIRECTOR	BOARD OF DIRECTOR MEETINGS ATTENDED
A Haigh (Chair)	12/12
D Anderson	12/12
A Graham	03/04 (appointed 1.12.17)
K Heaton	11/12
R Hopkin	10/12
A Nelson	05/06 (appointed 1.10.17)
P Oldfield	09/12
L Patterson	12/12
P Roberts	05/06
J Wilson	07/08
O Williams	12/12
H Barker	10/12
D Birkenhead	10/12
G Boothby	11/12
B Brown	09/12
S Dunkley	02/02 (appointed 1.2.18)
L Hill	11/12
I Warren	07/07 (resigned 9.7.17)

Appraisal of Board members

A robust appraisal process is in place for all board members and other senior executives. The Chairman appraises the Chief Executive, and the Chief Executive carries out performance reviews of the other executives.

The Chairman undertakes the performance review of Non-Executive Directors using the Trust's appraisal documentation and the outcomes of these appraisals are reported to the Council of Governors. During 2017-18, the performance review of the Chairman was led by the Senior Independent Non-Executive Director in accordance with a process agreed by the Council of Governors. All Governors are invited to contribute to the appraisal process for the Chairman. The outcome is then reported to the Council of Governors by the Senior Independent Non-Executive Director.

Biographies of the Board of Directors

Our Board of Directors is a unitary board, and has a wide range of skills with a number of directors having a medical or nursing background. The Non-Executive Directors have wide-ranging expertise and experience with backgrounds in finance, audit, estates, property, business development, primary care, human resources, organisational development and research. The Board believes that it is balanced and complete in its composition and appropriate to the requirements of the organisation. All of the Non-Executive Directors are considered independent.

Andrew Haigh
Chair

Appointment: July 2011 to March 2018

Andrew was appointed as Chairman of the Trust in July 2011. He trained locally as a chartered accountant with Armitage & Norton and moved to KPMG in Leeds when the two firms merged in 1987. He specialised in IT risk management and audit, particularly within retail financial services and the public sector eventually leading the IT Advisory practice for the KPMG in the UK and the Financial Services practice in the North of England. He became a Non-Executive Director of the Trust in December 2010. He is also a Non-Executive Director at Furness Building Society in Barrow. Andrew has lived in Huddersfield all his life.

Philip Lewer
Chair

Appointment: 1 April 2018

Philip was born in Lancashire and has lived in Yorkshire for over 40 years. His professional career began as a Mental Welfare Officer. He has worked for Bradford Council and was the Group Director for Health and Social Care at Calderdale Council, and a Regional Director for the Department of Health where he also served on the governments Standing Commission on Carers. He was chair of 'Mind the Gap' theatre company and a non-executive at Calico Housing. He was, until February 2018, Chair of NHS Leeds South and East Clinical Commissioning Group for over 5 years.

Owen Williams
Chief Executive

Appointed: May 2012
Owen has been the Chief Executive of Calderdale and Huddersfield NHS Foundation Trust (CHFT) since May 2012. This represents his third Chief Executive role across Local Government and the NHS during a career which has spanned both the public and private sectors. He is also a Trustee of the NHS Confederation, a national body that brings together, and speaks on behalf of, the whole health and care system. He is passionate about providing compassionate care built on CHFT's four pillars of putting the patient first; going to see; working together to get results and doing the must do's. Owen believes that diversity of leadership and greater colleague engagement are essential to meeting increased expectations regarding the quality of care and patient safety, together with the reality of significant gaps in the financial resources available.

Helen Barker
Chief Operating Officer

Appointed: January 2016
Helen joined the Trust substantively as Chief Operating Officer on 1st January 2016; she held a similar post for the previous two years in Bradford having spent her career before that working in acute trusts in West Yorkshire. Helen is a nurse by background and remains committed to providing the best experience possible for both patients and staff. With experience of leading performance improvement and transformational change programmes she brings this expertise to services across the Trust and wider community.

David Birkenhead
Executive Medical Director

Initially appointed on an interim basis in June 2014. Permanent appointment from July 2015.
David has been working in the Trust as a Consultant Microbiologist since 2000. He has held a number of senior clinical leadership roles in the Trust and was appointed to the post of Medical Director in July 2015. He is currently taking a temporary break from his clinical duties as a Consultant Microbiologists to allow him to focus on his work as Medical Director. In addition to his medical degrees David was awarded a Doctorate from the University of Manchester for his research into Campylobacter bacteria. As Medical Director, David shapes and leads the clinical services delivered by the Trust in order to drive the best health outcomes. Current large scale projects include reviewing how the Trust delivers care across the community and the hospitals, the development of 7 day services, and the ongoing implementation and development of an electronic patient record. He is the Medical Director lead for Stroke and Pathology across West Yorkshire and Harrogate. The Medical Director provides a professional lead for allied health professionals and medical staff and as the Trust's Responsible Officer makes recommendations to the General Medical Council around medical revalidation. David also takes the lead on education and training, research and development and infection control.

Gary Boothby
Executive Director of Finance

Appointed: November 2016
Gary Boothby has been Finance Director since November 2016. Previously he was the Deputy Director of Finance from March 2016. Mr Boothby joined the Trust from the Mid Yorkshire Hospitals NHS Trust where he had been the Deputy Director of Finance. Mr Boothby has over 25 years NHS experience and has been a Chartered Management Accountant since 1996. A large part of his career has been in senior divisional finance roles at both Mid Yorkshire Hospitals NHS Trust and at Pennine Acute Hospitals where there was a strong track record of working closely with Divisions to deliver both patient improvements and financial efficiencies.

Brendan Brown
Executive Director of Nursing/Deputy Chief Executive

Appointed: June 2016
Brendan joined the Trust from Burton Hospitals, and has previously held Board positions at Chief Nurse, Chief Operating Officer and Deputy Chief Executive level. He trained as a nurse in Derby, and has a background in both acute hospital and community nursing and senior management positions. He holds a Masters with Distinction from the University of Nottingham, and is passionate about delivering consistent high quality patient care, staff and leadership development

Suzanne Dunkley
Executive Director of Workforce and Organisational Development

Appointed: February 2018
Suzanne joined the Trust in 2018 with experience across both the private and public sector in strategic HR roles. Beginning her career at Pinderfields Hospital, Suzanne spent eight years leading a dotcom before moving into Local Authority and Transport Sectors. Suzanne believes that the role of HR is to spot talent and help it grow, that a great employee experience leads to a great patient experience.

Lesley Hill
Executive Director of Planning, Estates and Facilities

Appointed: May 2006
Lesley started her NHS career as a Pharmacist, and then went into NHS management and has done a wide variety of operational and commercial roles in Hospital Trusts and commissioning bodies. Lesley joined the Trust as Director of Service Development and has since moved on to her current portfolio. She now leads the Estates work across West Yorkshire Acute Association of Trusts (WYAAT) and has lead responsibility at Calderdale and Huddersfield NHS Foundation Trust for Estates and Facilities, health and safety, emergency planning, security management and the PFI contract and its services at Calderdale Royal Hospital.

Ian Warren
Executive Director of Workforce and Organisational Development
Appointed: August 2016 – July 2017
Ian left this post in July 2017.

Dr David Anderson
Non-Executive Director

Appointment: September 2011 to September 2018
David recently retired as 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 and has three children. David is committed to developing and delivering services in Calderdale and Huddersfield and recognises the benefits of more integration across hospital, primary care and local authority services. David is the Senior Independent Director and is a member of the Charitable Funds Committee.

Alistair Graham
Non-Executive Director

Alastair is the Director of Golden Lane Housing (GLH), a leading UK charity providing housing for over 1,700 people across England, Wales and Northern Ireland. Alastair has helped GLH to develop innovative new ways of enabling people with a learning disability to live and thrive as part of the mainstream community. Prior to this current role, Alastair led one of the largest regeneration programmes in the north of England as Director of the Oldham Rochdale Housing Market Renewal Pathfinder. Alastair has also worked in housing in a variety of housing and support roles in London and in Buckinghamshire. Alastair has a degree, a Diploma in Management Studies, the Chartered Institute of Housing Professional Qualification and is a fellow of the RSA. He has two sons and has lived in Calderdale for the past 25 years.

Karen Heaton
Non-Executive Director

Appointment: March 2016 to March 2019
Karen lives in Hade Edge, Holmfirth and is Director of Human Resources at the University of Manchester where she is responsible for developing and implementing people strategies to support the University's goal to be a world leading research led University by 2020.
Karen has held a number of senior human resource positions across different sectors including the not-for-profit and private sectors. As a member of the Chartered Institute of Personnel and Development she has operated as a Director Human Resources for over 25 years and is very experienced in transformational change within complex organisations.
Karen is a Non-Executive board member of One Manchester and Chair of the Remuneration Committee. Until recently she has also served as an independent member of the Prison Service Review Body advising the Government on pay and terms and conditions for staff in the prison service. Karen is Chair of the Workforce and Well Led Committee at the Trust.

Richard Hopkin
Non-Executive Director

Appointment: March 2016 to March 2019
Richard Hopkin lives in Sowerby Bridge and is a chartered accountant with 20 years' commercial experience as Finance Director / Company Secretary with two PLCs and a large private company, following 11 years in the accounting profession with a major international firm. He now runs his own business, providing financial consultancy advice, primarily to small and medium-sized enterprises and voluntary sector organisations. He is also a Non-Executive Director of a housing association, Derwent Living, and is Treasurer of the Community Foundation for Calderdale. Within the Trust, he Chairs the Audit and Risk Committee and is a member of the Finance and Performance Committee, Security Resilience and Governance Group and Pharmacy Manufacturing Unit Board.
Richard is married with two children.

Andy Nelson
Non-Executive Director

Andy is an experienced Technology and Business Transformation executive with a successful 30-year track record in Central Government, Management Consulting, Retail and Finance sectors. Key positions held include being the group executive with global responsibility for Strategy, IT and turnaround programmes at RSA Insurance and several large-scale CIO roles in the private and public sectors including HM Government CIO. He is now working in a non-executive, advisory, teaching and voluntary capacity for a wide range of organisations. He is a Non-Executive for the Disclosure and Barring Service and for The Law Society, a guest lecturer at Lancaster University Management School and is a volunteer with the Princes Trust. With the Trust he is a member of the Audit and Risk Committee and the Finance and Performance Committee. He is married with three grown-up sons and has lived in Barkisland since 1996.

Philip Oldfield
Non-Executive Director

Appointment: September 2013 to September 2019
Phil is a Chartered Accountant and MBA and he has a wide range of senior management experience within Retail, Manufacturing, Healthcare and Consultancy. He has over 15 years' experience at Board level and has held a number of senior management roles in Logistics, IT and Operations. Previous Healthcare experience includes Finance and Commercial Director for Nuffield Hospitals, Finance Director for Health and Social Care in Guernsey and a number of consultancy projects across the NHS. Up to early 2016 Phil was also Finance Director for the Sue Ryder Charity. Phil grew up in the Huddersfield area. Phil is Chair of the Finance and Performance Committee, is a member of the Audit and Risk Committee, Charitable Funds Committee and Workforce Well-Led Committee.

Dr Linda Patterson
Non-Executive Director

Appointment: October 2013 to September 2019
Dr Linda Patterson OBE lives in Hebden Bridge and was a consultant physician in general and geriatric medicine. She worked in clinical practice at the East Lancashire Hospitals Trust. She has been a clinical director, and has been at Board level for over 20 years as a Trust Medical Director, and the medical director of the first NHS regulator of quality, the Commission for Health Improvement (now the Care Quality Commission). She has also been a Non-Executive director for the National Patient Safety Agency. She was Clinical Vice-President of the Royal College of Physicians 2010-13 and is a Trustee of the Healthcare Quality Improvement Partnership (HQIP) which oversees the national clinical audits. She is passionate about improving quality of care, particularly using patient experiences to drive up quality. Linda chairs the Quality Committee

Professor Peter Roberts
Non-Executive Director
Appointment: September 2011 to September 2017
Professor Roberts completed his tenure as Non-Executive Director in September 2017.

Jan Wilson
Non-Executive Director
Appointment: December 2011 to November 2017
Jan was Deputy Chair of the Trust prior to the completion of her tenure in November 2017.

Register of Directors' Interests
All members of the Board must disclose details of company directorships and other positions held, particularly if they involve companies or organisations likely to do business or seeking to do business with the Trust. The Trust holds a register detailing any interest declared by a member of the Board of Directors. A copy of the register is available on the Trust's website at www.cht.nhs.uk or can be requested by writing to:
The Company Secretary
Calderdale and Huddersfield NHS Foundation Trust
Acre Street
Lindley
Huddersfield
HD3 3EA

Committees of the Board of Directors

The Board of Directors has six committees. Two are required as set out in the Trust's Standing Orders:
- Nominations and Remuneration Committee – see Remuneration Report pxx.
- Audit and Risk Committee

In addition, the Board has established four committees to carry out detailed scrutiny and provide assurance on key areas of the Trust business:
- Quality Committee
- Finance and Performance Committee
- Workforce Well-led Committee
- Estates Sustainability Committee

Each committee is chaired by a non-executive director/ independent member and is supported by executive directors and managers from across the Trust.

Audit and Risk Committee – Chaired by Professor Peter Roberts and Richard Hopkin
The role of the Audit and Risk Committee is to review critically the governance and assurance processes on which the Board places reliance, to ensure the long-term viability of the organisation. The Committee is charged with ensuring the adequacy and effective operation of the overall control systems of the organisation, with specific focus on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives.

The Audit and Risk Committee has approved terms of reference which are reviewed annually and are available on request.

The membership of the Audit and Risk Committee during 2017/18 was:
- Professor Peter Roberts – Non-Executive Director and Chair of the Committee (until 30.9.17)
- Richard Hopkin – Non-Executive Director and Chair of the Committee (from 1.10.17)
- Phil Oldfield – Non-Executive Director
- Andy Nelson – Non-Executive Director (from 1.10.17)

The Committee was supported by a number of officers from the Trust:
- Gary Boothby – Executive Director of Finance
- Victoria Pickles – Company Secretary

One Council of Governors is also invited to attend and observe each meeting.

The Trust and the Committee are supported by the Internal Audit and Counter-fraud Service provided by Audit Yorkshire and its external auditors KPMG. If necessary, the Committee may also seek independent legal or other professional advice.

The Committee met five times during 2017/18. The meeting in May specifically looks at the Annual Report and Accounts. The attendance at the Committee for the financial year 2017/8 was:

Member	Attended
Professor Peter Roberts	3/3
Phil Oldfield, Non-Executive Director	5/5
Richard Hopkin, Non-Executive Director	5/5
Andy Nelson	1/2

The principal activities of the Committee over the year were

Financial Reporting

The primary role of the Committee in relation to financial reporting is to review, with both management and the external auditor, the appropriateness of the annual financial statements concentrating on:

- the quality and acceptability of accounting policies and practices;
- the clarity of the disclosures, compliance with financial accounting standards and the relevant financial reporting requirements;
- material areas in which significant judgements have been applied or there has been discussion with the external auditor.

To aid the review, the Committee received reports from the Director of Finance and also reports from the external auditor on the outcomes of their interim and year-end audit process.

The key significant risks highlighted by the external auditor in their 2017/18 plan were:

- Valuation of fixed assets
- Recognition of NHS Income
- Accounting valuation of the EPR system
- Accounting treatment of assets transferred to Calderdale & Huddersfield Solutions Ltd
- Value for money risk given the Trust's continued breach of licence position

The external auditor's audit report following the completion of the audit provided the Committee with assurance on the material correctness of the valuation of fixed assets, and the audit report provided a qualification on the Trust's value for money arrangements as a result of the continued breach of licence.

The Committee received a paper from the Director of Finance detailing the evidence to support the Trust's going concern status. The Committee reviewed this paper and confirmed their support for recommending to the Trust Board that the financial statements should be prepared on a going concern basis.

Governance and Risk Management

During the course of the year the Committee has continued to ensure the Trust's governance arrangements are reviewed in line with the Code of Governance for Foundation Trusts published by NHS Improvement. Any changes are reflected within the relevant Trust policies and procedures and reported to the Committee for approval.

At the start of the year the Committee approved a number of minor amendments to the Trust's Standing Orders.

The Committee has continued to pay particular attention to the Trust's risk management arrangements and reviewed the Risk Management Strategy and Policy. The Committee also received a report on a review of the risk management arrangements of the Trust which provided an overview of activity undertaken to strengthen risk management processes within the Trust from ward to Board from August 2016 to September 2017. It was agreed that the Committee would consider this information annually. In addition the Committee reviewed and approved updated terms of reference for the Risk and Compliance Group.

The Committee reviews, on a regular basis, the risks that are described within the Trust's Board Assurance Framework and Trust Risk Register. The Committee has oversight of, and relies on the work of the Risk and Compliance Group to monitor compliance registers and risk registers and performance against national risk and safety standards. Internal audits of the Board Assurance Framework and divisional risk management arrangements resulted in significant assurance.

Of particular importance is the review of the disclosure statements that flow from the Trust's assurance processes with internal control weaknesses described within the Annual Governance Statement. The Committee discussed and agreed upon the disclosed areas of internal control gaps as described within the 2017/18 Annual Governance Statement.

The Committee undertook a self-assessment and identified a number of actions to improve its effectiveness. These included:

- Reviewing the process for receiving assurance on the governance arrangements of other committees
- Development of a map of internal and external sources of assurance
- Further work to be done on the use of the Board Assurance Framework in the Committee based on recommendations from Internal Audit on good practice elsewhere

Regulatory Relationships

The internal audit and counter fraud service is supplied by NHS Audit Yorkshire.

The Committee receives regular reports from the Internal Auditor and Local Counter Fraud Specialist.

The Committee agrees a defined work plan and monitors progress against this plan in addition to any specific, pro-active pieces of work that have been identified by management within the year.

The plans as agreed for 2017/18 and the additional work programmes were completed and culminated in an annual opinion of significant assurance from the Head of Internal Audit (HOIA).

The HOIA opinion is received and discussed by the Committee as part of the year end assurance process.

External Audit
The external audit service is provided by KPMG LLP (KPMG). KPMG was appointed on 1 October 2017 following a market testing exercise in the summer of 2017.

The appointment process followed the guidance issued by Monitor and resulted in the approval of KPMG by the Council of Governors at their meeting in October 2017.

The Committee recognise that non-audit related services can be provided by KPMG. In order to maintain KPMG's independence, the Committee has been informed of the robust internal procedures that KPMG apply when considering the undertaking of any non-audit services. In addition to this control, any significant non-audit services would require the pre-approval of the Committee. In the year 2017/18 there were no significant non-audit related services provided by KPMG.

The Committee reviewed and approved the External Audit plan for 2017/18. The auditors explained the programme of work they planned to undertake to ensure that the identified audit risks did not lead to a material misstatement of the financial statements and it is through the monitoring of this audit plan that the Committee gain assurance of the quality and effectiveness of the service received from KPMG.

The key audit risks they identified for 2017/18 were:

- Four significant risks identified for the Trust
  - ~ Valuation of land and buildings
  - ~ Recognition of NHS and non-NHS income
  - ~ Electronic patient record asset valuation, and
  - ~ Estates Special Purpose Vehicle

- the two significant risks mandated by International Standards for Auditing (ISAs):
  - ~ Fraudulent Recognition of income
  - ~ Management override of controls

- Value for money – financial sustainability

As part of the year-end audit process the auditor confirmed that there are no material misstatements within the financial statements. The auditors also reported the misstatements that they had found in the course of their work and confirmed that there were unadjusted audit differences relating to the impairment of the EPR system and the transfer of assets to Calderdale & Huddersfield Solutions Ltd. The auditor confirmed their intention to issue an unqualified audit opinion.

The fee for the audit was £55,000 (plus VAT).

Expressions of Concern, including Whistleblowing

The Committee maintains, on behalf of the Trust, an oversight function with regards to expressions of concern, including whistleblowing. This function acts as a backstop to the processes that are in place within the Trust.

Other areas of focus
During the year the Audit and Risk Committee considered a number of other key areas:

- Following the internal audit on payroll, the Committee asked for regular reports and assurance that progress was being made to address control issues identified;
- The Committee received reports on counter fraud work and investigations
- The Committee approved a draft amended conflicts of interest policy based on the national guidance. This will be implemented during 2018 dependent on the development of a system to support the process. This will continue to be an area of focus for 2017/18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Directors' Statements

Details of political donations

The Board confirmed that no political donations have been made during the year.
Compliance with HM Treasury cost allocation and charging guidance

The Trust has fully complied with all guidance relating to cost allocation and charging guidance.

Better payment practice code

Our Trust is committed to dealing fairly and professionally with all of our supplier partners. One way that we do this is by working to the Better Payment Practice Code. In short, this means that we aim to pay at least 95% of invoices within the agreed terms, unless there is a dispute. For most of our partners, this would be within 30 days of the date of invoice. During the year the Trust has not met the 95% target, however action continues to take place to improve performance against this target.

Better Payment Practice Code - 16/17						
Paid to	**Total Invoices paid - Volume**	**No Invoice's Paid on Time - Volume**	**% paid within target**	**Total Invoices paid - £**	**Value Paid on Time**	**% £ paid within target**
Non - NHS Orgs	119,442	85,884	71.90%	210,457,128.18	£168,926,440.48	80.27%
NHS - Orgs	2,311	1,571	67.98%	£10,240,957.43	£7,376,798.90	72.03%

Better Payment Practice Code - 17/18						
Paid to	**Total Invoices paid - Volume**	**No Invoice's Paid on Time - Volume**	**% paid within target**	**Total Invoices paid - £**	**Value Paid on Time**	**% £ paid within target**
Non - NHS Orgs	90,059	41,824	46.44%	173,124,852.86	£109,246,006.26	63.10%
NHS - Orgs	1,936	771	39.82%	£20,574,990.88	£16,730,940.45	81.32%

Income disclosure

Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) requires that income from the provision of goods and services for the purposes of the health service in England must be greater than its income for the provision of goods and services for any other purpose. The Trust can confirm it has met these requirements. This is set out in Note 5 of the accounts.

Disclosure to the Auditors

All directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. All directors have 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 NHS foundation trust's auditor is aware of that information.

Preparation of the Annual Report and Accounts

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

Our accounts, which begin on p193 of this document, have been prepared under a direction issued by NHS Improvement under the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Patient Care - Quality Governance Reporting

Quality governance is an important aspect of the management of healthcare and supports the Trust in delivering safe and quality services to our patients.

We have in place quality governance arrangements from ward to board to ensure we can effectively monitor the delivery of care and learn lessons from any incidents or clinical issues across the Trust.

Throughout the year the Trust Board received a quarterly quality report, including updates on care quality indicators (CQUINS) as well as presentations on quality improvements in services, such as falls prevention and assurances regarding the delivery of actions to improve care, such as naso-gastric tube feeding. The Audit and Risk Committee also received an annual report on the work of the Quality Committee.

During 2017/18 the Trust continued to improve quality governance arrangements, including strengthening of clinical governance at ward level through the ward to board assurance programme. A revised ward to board assurance model was introduced in September 2017. This is carried out monthly (five patients per ward) and covers the 12 quality nursing priorities below:

- Confidence in caring
- Patient observations
- Pain management
- Elimination
- Pressure ulcers
- Falls assessment
- Nutrition and hydration
- Patient safety
- Infection control
- Environmental safety
- Person centred care
- Medicines management

The ward assurance tool is available to staff via the Trust Intranet and data can be viewed on the knowledge portal. Ward managers and matrons for each area use the results to identify any low scoring and repeat issues that require local action plans to be developed. The Trust monthly results are reported within the Trust integrated performance report.

Another key aspect of strengthening ward to Board assurance is a programme of Board to ward visits which enabled Board members to have sight of the key issues in care delivery and lead in developing the appropriate culture and climate to have open discussions about our Trust goals through:

- leading by example and constantly reinforcing the importance of clinical quality to all aspects of the organisation
- stimulating discussion with staff about what types of information the Board requires and needs to know in order to assure quality
- being visible and open to comments, questions and feedback from colleagues to understand their experience of working within the Trust
- serving as a conduit of information about the patient experience through the use of soft intelligence and compelling narrative
- connecting into the emotional content of the patient experience
- role-modelling appropriate behaviours around presenting and receiving negative feedback from and about patients.

Visits include an executive and a non-executive supported by a matron or lead for each area.

Board members familiarise themselves with the area being visited prior to the visit using available performance information. A note is made of the key points noted and any follow-up required. It is the responsibility of the Board members attending to ensure anything requiring immediate attention is raised with the relevant Director of Operations / Divisional Director of Associate Director of Nursing immediately following the visit.

Key themes are collated and discussed at a Board workshop twice a year. Board members use the information and experience they have gained through their visits to triangulate information being presented to the Board.

The Trust has revised its Risk Management Strategy during the year, ensuring the risk management framework and organisational governance structure for risk management is refreshed. During the year the Trust implemented a new Electronic Patient Record EPR) and a time limited EPR risk panel was established to ensure that any risks associated with the EPR programme became managed within the Trust's usual risk management framework, with oversight of this by the newly introduced divisional digital boards.

More information on quality governance is included within the Annual Governance Statement on p94 and the Quality Report starting on p119.

The Trust confirms that there are no material inconsistencies between the annual governance statement, the annual and the quarterly board statements.

Care Quality Commission registration

The Trust is required to register with the Care Quality Commission (CQC) and has full registration without conditions.

The CQC carried out an inspection of the Trust between 8th and 11th March 2016 as part of their comprehensive inspection programme. In addition, unannounced inspections were carried out on 16th and 22nd March 2016. The Trust was rated as requires improvement overall. These ratings still stand.

The reports from the CQC inspection were published on their website in August 2016 and can be found at the following link: http://www.cqc.org.uk/provider/RWY

The judgements made by the CQC following their inspection relating to the trust overall were:

Overall rating for this Trust:	**Requires Improvement**
Are services at this Trust safe?	Requires improvement
Are services at this Trust effective?	Requires improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires improvement

The CQC is currently carrying out checks on the locations registered by CHFT using their new way of inspecting services, reports will be published when the checks are complete.

An end of year report to the Quality Committee and Board of Directors detailed the Trust response to the CQC inspection report and the concerns raised at the time of the inspection. It provided a year-end position against all of the must and should do actions and how the plan has been managed, including the role of the CQC Response Group and ongoing discussions with the CQC management team. The arrangements for the ongoing management of the CQC inspection requirements is monitored through the Risk and Compliance group which reports to Audit and Risk Committee.

The CQC gave the Trust notice on 14th November 2017 of an intention to conduct an inspection using the new inspection methodology. This includes unannounced inspections of core services and an announced inspection of the Well Led domain. Reports from these visits will be published by the CQC when the inspections are complete. In preparation for these inspections, the Trust re-established a CQC Planning Group, reporting to the Quality Committee through monthly reports on progress against a well led action plan and Divisional core service plans, this includes any emerging risks.

Our Patients 2017/18

Patient Experience

1. Aims and Objectives of Work
Measuring patient experience is essential in order to assess the delivery of the Trust's vision: Together we will deliver outstanding compassionate care to the communities we serve along with the strategic goal of: Transforming and improving patient care.

Analysis of patient feedback helps us to better understand our patients' expectations, their experience and their satisfaction. For example their views of the environment in which their care and treatment was delivered, whether they were kept informed, whether they were treated with respect and dignity and how their interactions with staff made them feel.

It is important that the feedback is used to influence changes in practice; this may often be about the small things as well as any large system changes. Staff from across the Trust recognise the importance of listening and responding to patient and carers views, this is championed through the representatives on the Trust Patient Experience and Caring Group.

2. Feedback methods
The primary method of measuring the patient experience in the Trust remains through the Friends and Family Test (FFT) which is now well established across all inpatient and day case areas, as well as in the A&E and outpatient departments, maternity services and across community services. More innovative approaches continue to be introduced to gather feedback and create opportunities to 'listen', through a range of feedback options that sit alongside the more formal methods of FFT, complaints, patient advice service and surveys.

Over the last 12 months wards and departments have used a variety of other methods to encourage patient feedback, examples include direct contact through rounding by the ward managers and matrons, debriefs, guest books and graffiti boards. Opportunistic engagement is also carried out to gather service user opinions to support improvements the teams are taking forwards, as well as more formal enquiries to support service evaluations.

3. Friends and Family Test
The FFT question asks *"How likely are you to recommend our ward / department to friends & family if they needed similar care or treatment?"* Performance is monitored internally against national performance baselines.

Top 20%	Super Green
50%-79%	Green
21%-49%	Amber
Bottom 20%	Red

Information for the year for the FFT response rate as well as the percentage who would recommend the service is given below.

2017/8 % Response Rate & Would Recommend

	2017/18 (11 month data) Response Rate	2017/18 (11 month data) Would Recommend
Inpatient	31.1%	96.9%
A&E	10.1%	85.3%
Maternity	41.6%	97.5%
Community	6.8%	89.8%
Outpatients	10.1%	89.6%

4. Local Quality Improvement Work

The Trust has worked with external quality improvement partners, such as NHS Quest which focusses on improving quality and safety. During the year four staff have been involved in this Haelo improvement science for leaders programme. This works has focussed on falls prevention, with leaders from the Falls group undertaking this one year training programme improvement challenge. This has involved the clinical lead for falls, the health informatics services and clinical colleagues, nurses from the medical assessment unit. Further details of the improvement work on falls can be found in the quality account.

Work has taken place also to develop a quality improvement leaders network to help build quality capability and capacity throughout the organisation for quality.

The Trust Patient Experience and Caring Group has taken forward a number of priorities over the last 12 months described below.

PRASE (Patient Reporting and Action for a Safe Environment)

The Trust has worked with the Yorkshire & Humber Improvement Academy using the PRASE survey, which are conducted by trained volunteers at ward level. This approach enables patients to provide anonymised feedback (positive and negative) on the safety and quality of care experienced during their ward stay.

The questions are linked to the following eight safety domains:

- Communication and teamwork
- organisation and care planning
- access to resources
- the ward environment
- information flow
- staff roles and responsibilities
- staff training
- delays

Results for surgical wards have shown some excellent results, with feedback around 'communication and team work' and the responsiveness of staff to answering buzzers being particularly positive. Some opportunities for improvement were to improve 'organisation and care planning', with one ward conducting improvement work to help ensure staff and patients are aware of the plan of care and another ward making better use of ward space. The initial surveys were undertaken on some of the surgical wards, they have now been rolled out to other areas - medical and paediatric wards.

Experience Based Co-design (EBCD):

The Trust's Patient Experience and Caring Group have championed the use of EBCD as an opportunity for service users and staff to come together to design, monitor and improve the care provided. The Trust held two events during 2017 related to the reconfiguration of medical services - Respiratory and Frailty.

Outputs from the frailty event included working with patients to:

- Develop a patient/carer leaflet (draft shared with those present)
- Include information about tests, results and follow ups on the leaflet – discuss with patients/carers to assess whether this would provide the information they need (draft has been sent to EBCD participants)

Other ideas for improvement have been taken forward via the Frailty Operational Group, such as the development of staff competencies, including implementing advanced care plans and training staff to advanced practitioner level.

An event relating to End of Life care has also been held, dignity symbols, a bereavement card and a 'coffee mourning' were examples of ideas discussed and agreed and are being taken forward through the end of life care group.

National surveys

For all of the national surveys scores each question is scored out of 10, a higher score is better. Trust scores of each question in the survey are also compared with the range of results from all other Trusts that took part. An analysis technique called the 'expected range' is used to determine whether a Trust performs 'about the same', 'better' or 'worse' than other trusts. This analysis is based on a rigorous statistical analysis and therefore any scores outside the expected range means it performs significantly better / worse than what would be expected and unlikely to have occurred by chance.

Inpatient Survey: published May 2017, CHFT were reported as scoring about the same for all but one of the questions. The Trust was reported as scoring better than the majority of other Trusts for the question - 'If you brought your own medication into hospital, were you able to take it when you needed to?'

Emergency Department Survey: published October 2017, CHFT scored 'about the same' for all but one question –'Did a member of staff tell you about medication side effects to watch for? The Trust scored worse for this question.

Children and Young People Survey: published November 2017, CHFT scored 'about the same' for all but one question: Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs? The Trust scored worse for this question.

Maternity Survey: published January 2018, CHFT scored about the same for the majority of questions.

There were two questions where the Trust scored 'better':

- Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?
- Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

There was one question where the Trust scored' worse':

- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?

For the questions where the Trust scored 'worse' the services are taking forward actions. Progress with these will be monitored through their internal governance arrangements and reported through Divisional reports to the patient experience and caring group.

Staff posters have been produced to highlight some of the key messages from the surveys as an opportunity to share what patients say we do well, recent service improvements and any further actions to be taken.

Cancer Patient Experience Survey: published July 2017, CHFT scored outside the expected range on five questions (one better than and four lower than)

			2016 Case-mix Adjusted			
Question		Number of respondents for this Trust	2016 Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	National Average Score
Clinical Nurse Specialist						
Q17	Patient given the name of the CNS who would support them through their treatment	446	86%	87%	93%	90%
Q19	Get understandable answers to important questions all or most of the time	329	85%	85%	92%	88%
Support for people with cancer						
Q20	Hospital staff gave information about support groups	324	75%	79%	89%	84%
Q22	Hospital staff gave information on getting financial help	233	48%	49%	64%	56%
Your overall NHS care						
Q56	Overall the administration of the care was very good / good	462	93%	86%	93%	89%

The Trust's lead cancer nurse is working with each cancer team to deliver individual plans based on their results. The main focus for the teams is clinical nurse specialist interaction and the continued development of the cancer information service.

Our Patients 2017/18

Complaints

In line with the NHS regulations for complaints, we agree with all complainants how their complaint will be investigated and when they can expect to receive a written response.
During the year we have focussed on:

- Improving the timeliness of responses for complainants, so we respond in the timescale agreed, ensuring staff kept complainants updated about the progress of their complaint and ensuring that processes are in place to escalate any delays
- Training staff on complaints handling to improve the quality of our complaints investigations and learning from complaints
- Identifying learning from complaints to improve services for patients and working with Patient Experience leads on the patient Experience and Caring Group to inform this
- Undertaking a "go see" visit to another Trust to see how we can continue to improve our service
- Developing ways of seeking feedback from complainants, including a survey

We closely monitor the complaints investigations being carried out and report our performance against these quarterly to the Patient Experience and Caring Group and through a monthly performance report to the Board. This is supplemented by weekly monitoring reports to ensure that staff are aware of all complaints response deadlines.

During 2017/18 we received 615 complaints, of which 77% were upheld or partially upheld. There has been a very small decrease (0.3%) in the number of complaints received compared with 2016/17.

The highest number of complaints were about A & E services, which is consistent with national figures showing this as an area with a high number of complaints.

The main themes from complaints during the year were consistent with the previous year, being communication, patient care (including nutrition and hyrdartion) and clinical treatment.

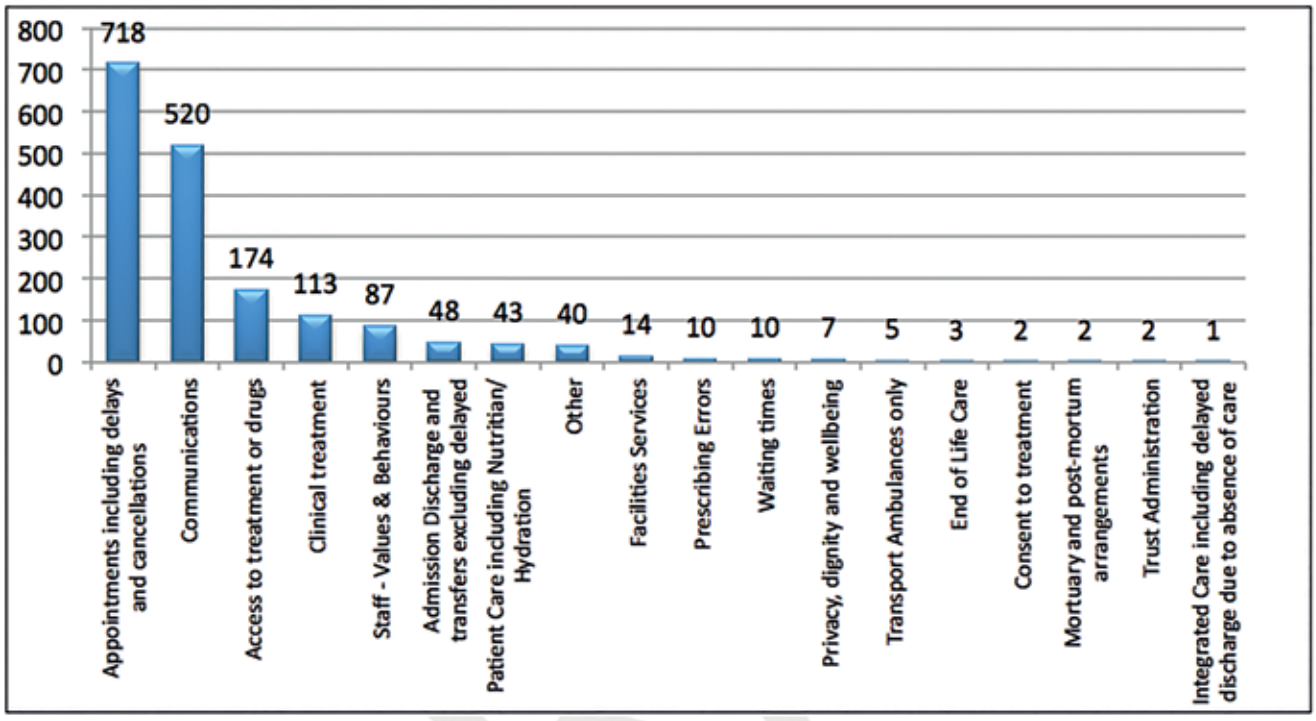
Complainants can request an independent review of their complaint by the Parliamentary Health Service Ombudsman, which is now investigating more complaints referred to them than in previous years. During 2017/18 seven complaints regarding the Trust were accepted by the Ombudsman for investigation. During 2017/18 eleven complaints investigations were completed; four complaints were not upheld, six were partially upheld and one was withdrawn. Further information on complaints is given in the Quality Account.

Patient Advice and Liaison Service (PALS)

The role of the PALS team is to be the first point of contact in the Trust for suggestions, answer queries and help resolve concerns promptly. They provide advice about the Trust's service and support people to get answers if they don't know who to ask.

During 2017/18 our PALS team dealt with 1994 contacts, a 121% increase in the number of concerns received in 2017/18 compared to 2016/17 940 concerns). Key themes were appointments and communication.

Analysis of Concerns by Theme



Appointments (including delays and cancellations) was the top subject of concern in 2017/18 representing 40%. This was an increase of 154% (from 283 concerns to 718) from 2016/17, which is indicative of the overall increase in concerns received. The second highest subject of concern was Communication representing 29% and the third highest subject was Access to Treatment or Drugs, representing 10% of all concerns in 2017/18.

Both Appointments (including Delays and Cancellations and Communications) figure prominently in both Complaints and Concerns.

The Trust introduced a new Electronic Patient Record system in May, which caused some unforeseeable problems with the appointment system. These have all been resolved.

Compliments

In 2017/18 260 compliments were received centrally by the Trust. This is a small proportion of the feedback that is sent directly to teams, wards and departments across our organisation. It is always a real pleasure to see the very kind cards, letters, emails and social media posts from patients, their family and friends thanking the staff that have cared for them and giving us feedback on how our services have made a difference. We share as much of this feedback as we can through the Trust's monthly newsletter, screensavers and weekly news round up. Wherever it is possible to identify a team or individual we send the feedback directly to them.

Here is just one of the compliments received in 2017/18:
"From the moment I was admitted to Huddersfield Royal Infirmary with a break of the hip my treatment and care was exemplary ….. I was truly impressed by the professionalism of everyone in terms of clinical judgement and treatment and the "joined up thinking" between operation and after-care and the overall engagement with patients."

More information about our learning from patient feedback is included in our Quality Account.

Stakeholder relations

The Trust continues to work closely with neighbouring health and social care organisations and agencies to provide safe, high quality healthcare to our local communities. Through collaborative working and effective relationships with all of our stakeholder's enables we can maximise the benefits to patients and have open and honest dialogue during challenging times.

We have worked closely with our local commissioners, and Health and Wellbeing Boards on the development of the Full Business Case to progress Right Time, Right Care, Right Place, and we are a key partner on the local Urgent Care and System Resilience Boards. We have representation on our Membership Council from both of our local authorities, the University of Huddersfield, Locala (a local community provider) South West Yorkshire Partnership Foundation Trust (the mental health care provider) and a single representative on behalf of both clinical commissioning groups.

Our relationships with the GP Federations remain strong in both Calderdale and Kirklees. Our clinical leaders are working with GP commissioners on an agreed clinical model for the future of hospital services and in particular a new model for outpatient care. We have also been an active partner in the development of the Multi-Specialty Community Provider Vanguard in Calderdale alongside the Calderdale GP Federation, South West Yorkshire Partnership Foundation Trust and Locala.

We have embraced the finding of the Health watch survey and are exploring pathways across the system for alternative models of outpatient care.

West Yorkshire Health and Care Partnership and delete West Yorkshire Association of Acute Trusts (WYAAT)

Proud to be part of the West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). It brings together all health and care organisations in our six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield.

In November 2016 the partnership published draft high level proposals. Since then the way the partnership works has been further strengthened by a shared commitment to deliver the best healthcare possible for the 2.6million people living across our area. This is priority to us all.

In February 2018, the Partnership published 'Our Next Steps to Better Health and Care for Everyone'. The document describes the progress made since the publication of the initial WY&H plan in November 2016 and sets out the next 12 months and beyond. You can read it at www.wyhpartnership.co.uk/next-steps or ask us for a printed copy.

WY&H HCP includes eleven clinical commissioning groups (which buy and plan healthcare for local people), eight local councils, and services provided by a number of health and social care organisations, including hospitals, mental health care providers, the ambulance service, HealthWatch, and community organisations.

The partnership is built on organisations working together in the West Yorkshire and Harrogate six local areas to meet the needs of people. Partners also work together on nine priority programmes for the whole of WY&H, including mental health, hospitals working together, maternity, stroke, urgent and emergency care; and improving peoples' wellbeing.

We know that more needs to be done to prevent ill health. Peoples' life chances are shaped in their early years of life and with an ageing population, helping frail and older people stay healthy and independent, tackling loneliness, and avoiding hospital stays unless needed is a priority. We also know that not only hospitals and doctors keep people well; a person's life choices and where they live are also important. Working alongside our communities is therefore essential and we are attracting support from community and unpaid carers organisations to help us to think about our next steps.

We have now developed our programmes of work into clear plans for delivery and begun to deliver in these important areas. Our aim includes better access to GP services weekends and evenings; reducing the number of people who take their own life; a reduction in waiting times for autism assessment; tackling alcohol related harm; reducing the number of people at risk of diabetes; and delivering programmes to support people to lose weight. A key part of our plans is rethinking the way urgent and emergency care is provided to ensure more options

are available away from hospital, ensuring our A&Es are supported by better primary and social care.

Our Partnership has attracted over £45m of national funding to further improve healthcare, so we can move quickly on our priorities. This includes £12.4 million of national funding to support work to improve early diagnosis and make more cancers curable, and funds to build a new mental health unit in Leeds for children and young people. We have also recently agreed an ambition to improve detection and management of Atrial Fibrillation (erratic heartbeat) and we estimate that this will prevent 190 strokes over 3 years. In addition, we continue to have meaningful conversations and effective engagement with staff and the public. A very important part of the way we work.

This is just a snap shot of some of the work the Partnership are doing – find out more at www.wyhpartnership.co.uk or follow us on twitter @ wyhpartnership.

West Yorkshire Association of Acute Trusts
Established during 2016 the West Yorkshire Association of Acute Trusts (WYAAT) is a collaboration which brings together NHS trusts delivering acute hospital services from across West Yorkshire and Harrogate to drive forward the best possible care for patients.

Membership of WYAAT includes: Airedale NHS Foundation Trust, Bradford Teaching Hospitals NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Leeds Teaching Hospitals NHS Trust and Mid Yorkshire Hospitals NHS Trust. Formal governance arrangements to enable collective decision making (including a Committee in Common) and a shared PMO function have been established.

The vision of WYAAT is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice consistently delivering the highest quality of care and outcomes for patients. The purpose of the collaborative programme is to reduce variation and deliver sustainable services to a standardised model which is efficient and of high quality.

The Board of each of the WYAAT trusts agreed to form a Committee in Common (CIC) which is responsible for leading the joint work programme and the development of work streams within the programme. The Chief Executive and Chair from each trust are members of the Committee in Common.

Each work stream has a number of projects underneath supported by a lead Chief Executive from one of the six trusts. The projects put together a case for change that sets out how things are done now, what good or best practice is, and how things need to change in the future. The cases for change are considered by the Committee in Common before being recommended to each of the individual trust boards for approval.

Key developments in 2017/18 include:

- ***Procurement:*** collaborative work between the WYAAT trusts on procurement
- ***Pharmacy:*** WYAAT's supply chain programme is being held up as a national exemplar and was recently approved by the WYAAT Committee in Common to move into the procurement phase.
- ***Information &Technology:*** WYAAT trusts are already implementing a common system in Radiology and are also exploring the potential for common IT systems in pathology.
- ***Workforce:*** exploring the potential to collaborate to standardise workforce policies and processes. This work will include streamlining a number of areas such as recruitment checks, statutory and mandatory training, and job planning principles for the medical workforce.
- ***Elective Surgery*** and ***Vascular Services*** work programmes continue to progress.

Remuneration Report

I am pleased to present the Remuneration Report for 2017/2018. At Calderdale and Huddersfield NHS Foundation Trust we recognise that our remuneration policy is important to ensure that we can attract and retain skilled and experienced leaders who are able to deliver our ambitious plans for delivering compassionate care. At the same time it is important to recognise the broader economic environment and the need to ensure we deliver value for money.

The report outlines the approach adopted by the Nomination and Remuneration Committee when setting the remuneration of the executive directors and the other executives who have authority or responsibility for directing or controlling the major activities of the organisation. The following posts have been designated as fitting the criteria by the committee and are collectively referred to as the executives within this report:-

- Chief Executive
- Chief Operating Officer
- Director of Finance
- Director of Nursing / Deputy Chief Executive
- Medical Director
- Director of Planning, Estates and Facilities
- Director of Workforce and Organisational Development

The Committee also considers other director-level posts that are not members of the Board.

Details of the membership of the Nomination and Remuneration Committee and individual attendance can be found on p81 of this report.

Annual statement on remuneration

The Nominations and Remuneration Committee (Board of Directors), in setting the pay of the Executive Directors based its decisions on Department of Health guidance and available benchmarking data.
The membership of the committee during 2017/18 was as follows:
Andrew Haigh – Chairman
Dr David Anderson – Non-Executive Director
Alastair Graham – Non Executive Director (from 1.12.17)
Karen Heaton – Non-Executive Director
Andy Nelson – Non-Executive Director (from 1.10.17)
Phil Oldfield – Non-Executive Director
Dr Linda Patterson – Non-Executive Director
Jan Wilson – Non-Executive Director (to 01.12.17)
Richard Hopkin – Non-Executive Director (for nomination items only from 1.10.17)
Prof Peter Roberts – Non-Executive Director (for nomination items only to 30.9.17)

Advice to the Committee was provided by the Executive Director of Workforce and Organisational Development (at the meeting on 1 March 2018) and through the review of external benchmarking reports.

During 2017/18 the Committee met on two occasions and the meetings and were attended by all required members except Dr Linda Patterson (for the meeting on 22 September 2017) and Andy Nelson (for the meeting on 1 March 2018).

The Committee reviewed its terms of reference and, having regard to the Association of NHS Providers 'Good Governance' in accordance with the Committee's terms of reference it was agreed:

- Review of Terms of Reference – no changes made
- Recruitment to the post of Managing Director – Digital Health
- Recruitment to the post of Executive Director of Finance
- Recruitment to the post of Executive Director of Workforce and Organisational Development.
- In the financial year 2016/17, in accordance with the national position on pay for NHS staff, having reviewed the benchmarking information from NHS Providers and having regard to the Trust's financial position it was agreed that there be a 1% uplift offered to the Directors.

Remuneration Policy
The Trust's remuneration policy applies equally to Non-Executive Directors, Executive Directors and senior below Board level posts and 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.

When setting levels of remuneration, the Trust's Nominations and Remuneration Committees take into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. The Committees also receive professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.' The way in which the Committees operate is subject to audit scrutiny. The work of the Committees is subject to an independent level of scrutiny by the Audit and Risk Committee and this scrutiny can be exercised at any time. The scrutiny role is set out in the Terms of Reference of the Audit and Risk Committee and the Committee Chair does not sit on the Remuneration part of the Nomination and Remuneration Committee.
The Trust has well established performance management arrangements and each year I undertake an appraisal for each of the executives and I am appraised by the Chairman. We do not have a system of performance-related pay and therefore in any discussion on remuneration an individual's performance is considered alongside the performance of the executive team and the organisation as a whole.

The Executive Directors are employed on permanent contracts with a six month notice period. In any event where a contract is terminated without the executive receiving full notice, compensation would be limited to the payment of the salary for the contractual notice period. There would be no provision for any additional benefit over and above standard pension arrangements in the event of early retirement. Non-Executive Directors are requested to provide six months' notice should they wish to resign before the end of their tenure. They are not entitled to any compensation for early termination. The Trust has no additional service contract obligations.

Salary and pension contributions of all executive and non-executive directors
Information on the salary and pensions contributions of all executive and non-executive directors is provided in the tables on the following pages. The information in these tables has been subject to audit by our external auditors KPMG LLP. Additional information is available in notes from p200 of the accounts.

Owen Williams
Chief Executive
23 May 2018

Salary, Expenses 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	2017-18					
	Salary	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5,000) £000	£	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
A Haigh ~ Chair	50 - 55	0	0	0	0	50 - 55
D Anderson ~ Senior Independent Non Executive Director	10 - 15	0	0	0	0	10 - 15
J Wilson ~ Vice Chair (Note A)	5 - 10	0	0	0	0	5 - 10
L Patterson ~ Chair of Quality Committee	10 - 15	0	0	0	0	10 - 15
P Oldfield ~ Deputy Chair and Chair of Finance & Performance Committee (Note B)	10 - 15	0	0	0	0	10 - 15
Prof P Roberts ~Independent Member (Note C)	10 - 15	0	0	0	0	10 - 15
R Hopkin ~ Chair of Audit and Risk Committee (Note D)	10 - 15	0	0	0	0	10 - 15
K Heaton ~ Chair of Workforce (Well Led) Committee	10 - 15	0	0	0	0	10 - 15
A Nelson ~ NED (Note E)	5 - 10	0	0	0	0	5 - 10
A Graham ~ NED (Note F)	0 - 5	0	0	0	0	0 - 5
G Boothby ~ Director of Finance (Note G)	125-130	0	0	0	147.5 -150	275 - 280
L Hill ~ Director of Planning and Estates & Facilities	135-140	0	0	0	30 - 32.5	165 - 170
I Warren ~ Director of Workforce and Organisational Development (Note H)	105 -110	0	0	0	5 -7.5	110 - 115
J Eddleston ~ Director of Workforce and Organisational Development (Note I)	60 - 65	0	0	0	85 - 87.5	150 - 155
S Dunkley ~ Director of Workforce and Organisational Development (Note J)	20 - 25	0	0	0	2.5 - 5	25 -30
D Birkenhead ~ Medical Director	225-230	0	0	0	27.5 -30	255 -260
B Brown ~ Deputy Chief Executive/Director of Nursing	140-145	5,900	0	0	32.5 - 35	175 -180
H Barker ~ Chief Operating Officer	135-140	0	0	0	20 - 22.5	155 - 160
O Williams ~ Chief Executive	185 -190	0	0	0	30 - 32.5	220 - 225
Additional disclosure						
Band of the highest paid Director's total remuneration	225-230					
Median Total (£'000)	27,425					
Remuneration ratio	8					

Name and Title	2016-17					
	Salary	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonus	Pension Related Benefits	Total
	(bands of £5,000) £000	£	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
A Haigh ~ Chair	50 - 55	0	0	0	0	50 - 55
D Anderson ~ Senior Independent Non Executive Director	10 - 15	0	0	0	0	10 - 15
J Wilson ~ Vice Chair	10 - 15	0	0	0	0	10 - 15
L Patterson ~ Chair of Quality Committee (Note K)	5 - 10	0	0	0	0	5 - 10
P Oldfield ~ Chair of Finance & Performance Committee	10 - 15	0	0	0	0	10 - 15
Prof P Roberts ~ Chair of Audit & Risk Committee	15 - 20	0	0	0	0	15 - 20
R Hopkin	10 - 15	0	0	0	0	10 - 15
K Heaton ~ Chair of Workforce (Well Led) Committee	10 - 15	0	0	0	0	10 - 15
K Griffiths ~ Director of Finance (Note L)	85-90	0	0	0	15 - 17.5	100 - 105
G Boothby ~ Director of Finance (Note G)	50-55	0	0	0	25 - 27.5	75 - 80
L Hill ~ Director of Planning and Estates & Facilities	130-135	0	0	0	30 - 32.5	165 -170
J Hull ~ Director of Workforce and Organisational Development (Note M)	115-120	0	0	0	0 - 2.5	115 - 120
I Warren ~ Director of Workforce and Organisational Development	80-85	0	0	0	25 - 27.5	105 - 110
D Birkenhead ~ Medical Director	225-230	0	0	0	30 - 32.5	260 - 265
J Dawes ~ Director of Nursing (Note N)	10-15	0	0	0	0 - 2.5	10 -15
B Brown ~ Deputy Chief Executive/Director of Nursing (Note O)	110-115	0	0	0	15 - 17.5	125 -130
H Barker ~ Chief Operating Officer	135-140	0	0	0	132.5 - 135	270 - 275
O Williams ~ Chief Executive	185-190	0	0	0	42.5 - 45	230 -235
Additional disclosure						
Band of the highest paid Director's total remuneration	225 - 230					
Median Total (£'000)	27,043					
Remuneration ratio	8					

Non-Executive Directors do not receive pensionable remuneration; there will be no entries in respect of pension related benefits for Non-Executive Directors.

A. J Wilson left 30.11.17
B, P Oldfield, Deputy Chair from 1.12.17
C, Prof P Roberts, NED – until 23.9.17 Independent Member from 23.9.17
D, R Hopkin, – appointed as Chair of Audit and Risk Committee from 22.9.17
E, A Nelson, NED - from 1.10.17
F, A Graham, NED - from 1.12.17
G, G Boothby appointed 01.11.16
H, I Warren - left 31.07.17.
I, J Eddleston - acting dates: 11.07.17 – 31.01.18
J, S Dunkley appointed on 01.02.18
K, L Patterson on sabbatical from 01.01.16 - 01.09.16
L, K Griffiths left 28.10.2016
M, J Hull left 31.07.16
N, J Dawes left 30.04.16
O, B Brown appointed to Director of Nursing 13.06.16, appointed to Deputy Chief Executive 06.02.17

B Brown was paid £13,894 for removal expenses in 17/18, of which £5,900 was a taxable benefit.

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 2017/18 was £228k (2016/17 was £228k). This was 8 times (2016/17, 8) the median remuneration of the workforce, which was, £27,425 (2016/17, £27,043).

In 2017/18, 2 (2016/17, 3) employees received remuneration in excess of the highest paid director. In 17/18 remuneration ranged from £234k to £334k (2016/17 £232k to £254k).

The salary for the Medical Director is their total remuneration package, of which £52k relates to their clinical role.

The Trust has two senior managers who are paid more than £150,000 per annum

B) Pension Benefits								
Name and title	**Real increase in pension at age 60 (bands of £2,500)**	**Real Increase in Lump sum at age 60 (bands of £2,500)**	**Total accrued pension at age 60 at 31 March 2018 (bands of £5,000)**	**Lump sum at age 60 related to accrued pension at 31 March 2018 (bands of £5,000)**	**Cash Equivalent Transfer Value at 1 April 2017**	**Real Increase/ (Decrease) in Cash Equivalent Transfer Value**	**Cash Equivalent Transfer Value at 31 March 2018**	**Employer's contribution to stakeholder pension**
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
G Boothby ~ Director of Finance (Note G)	7.5 - 10	7.5 - 10	45 - 50	70 - 75	459	125	588	0
L Hill ~ Director of Planning and Estates & Facilities	0 - 2.5	0 - 2.5	50 - 55	150 -155	932	89	1,029	0
I Warren ~ Director of Workforce and Organisational Development (Note H)	0 - 2.5	0 - 2.5	15 - 20	0 - 5	198	11	232	0
J Eddleston ~ Director of Workforce and Organisational Development (Note I)	5 - 7.5	12.5 - 15	40 - 45	85 - 90	547	108	702	0
S Dunkley ~ Director of Workforce and Organisational Development (Note J)	0 - 2.5	0 - 2.5	0 - 5	0 - 5		3	20	0
D Birkenhead ~ Medical Director	2.5 - 5.0	0 - 2.5	75 - 80	215 - 220	1,396	67	1,476	0
B Brown ~ Deputy Chief Executive/ Director of Nursing	2.5 - 5.0	0 - 2.5	05 - 10	0 - 5	34	27	61	0
H Barker ~ Chief Operating Officer	0 - 2.5	0 - 2.5	55 - 60	150 -155	943	75	1,028	0
O Williams ~ Chief Executive	2.5 - 5.0	0 - 2.5	70- 75	0 - 5	786	82	876	0

Cash Equivalent Transfer Values

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

Real Increase/ (Decrease) in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period."

Staff Report

We employ 6095 colleagues across our two hospitals and in the community in Calderdale.

Gender

Director*	 10 (67%) Male	 5 (33%) Female
Senior Manager	 46 (33%) Male	 79 (67%) Femaile
Other employees	 1061 (18%) Male	 4894 (82%) Femaile

* includes Non-Executive Directors

Staff costs

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead.

Staff costs							
					2017/18		**2016/17**
			Other		**Total**		**Total**
	£000		£000		**£000**		£000
Salaries and wages	184,091		5,023		**189,114**		180,742
Social security costs	17,515		-		**17,515**		16,594
Apprenticeship levy	915		-		**915**		-
Employer's contributions to NHS pensions	22,893		-		**22,893**		22,087
Pension cost - other	16		-		**16**		-
Other post employment benefits	-		-		**-**		-
Other employment benefits	-		-		**-**		-
Termination benefits	-		-		**-**		-
Temporary staff			17,005		**17,005**		23,439
Total gross staff costs	**225,430**		**22,028**		**247,458**		**242,862**
Recoveries in respect of seconded staff	-		-		**-**		-
Total staff costs	**225,430**		**22,028**		**247,458**		**242,862**
Of which							
Costs capitalised as part of assets	2,367		148		**2,515**		1,954

Average number of employees (WTE basis)							
					2017/18		2016/17
	Permanent		Other		Total		Total
	Number		Number		Number		Number
Medical and dental	282		357		**639**		609
Ambulance staff	-		-		**-**		-
Administration and estates	1,243		153		**1,396**		1,245
Healthcare assistants and other support staff	1,026		206		**1,232**		1,239
Nursing, midwifery and health visiting staff	1,610		138		**1,748**		1,779
Nursing, midwifery and health visiting learners	-		-		**-**		-
Scientific, therapeutic and technical staff	535		30		**565**		529
Healthcare science staff	105		1		**106**		118
Social care staff	-		-		**-**		-
Other	-		-		**-**		-
Total average numbers	**4,801**		**885**		**5,686**		**5,519**
Of which:							
Number of employees (WTE) engaged on capital projects	56		-		**56**		45

Reporting of compensation schemes - exit packages 2017/18					
		Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages
		Number		Number		Number
Exit package cost band (including any special payment element)						
<£10,000		-		-		**-**
£10,001 - £25,000		-		-		**-**
£25,001 - 50,000		1		-		**1**
£50,001 - £100,000		-		1		**1**
£100,001 - £150,000		-		-		**-**
£150,001 - £200,000		-		-		**-**
>£200,000		-		-		**-**
Total number of exit packages by type		**1**		**1**		**2**
Total resource cost (£)		£28,000		£71,000		**£99,000**

Reporting of compensation schemes - exit packages 2016/17				
	Number of compulsory redundancies	**Number of other departures agreed**	**Total number of exit packages**
	Number	**Number**	**Number**
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,001 - £25,000	-	-	**-**
£25,001 - 50,000	1	-	**1**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	1	-	**1**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**2**	**-**	**2**
Total resource cost (£)	£171,000	£0	**£171,000**

Exit packages: other (non-compulsory) departure payments				
	2017/18		**2016/17**	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	**-**
Mutually agreed resignations (MARS) contractual costs	-	-	-	**-**
Early retirements in the efficiency of the service contractual costs	-	-	-	**-**
Contractual payments in lieu of notice	1	71	-	**-**
Exit payments following Employment Tribunals or court orders	-	-	-	**-**
Non-contractual payments requiring HMT approval	-	-	-	**-**
Total	**1**	**71**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	**-**

This was a mutual agreed termination based on the changed personal circumstances of the post holder. All our payroll engagements are subject to a risk-based assessment and where considered necessary, we seek assurance as to whether the individual is paying the right amount of tax. The Trust is continuing to work with agencies to ensure contractual clauses are in place.

Off payroll engagements

Table 1: For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2018	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	9

Consultancy spend

During 2017/18 the Trust spent £145,000 on consultancy.

A workforce fit for the future

2016 National Staff Survey

Following the publication of the national NHS staff survey results in March 2018, we intend to use this feedback to build on the robust action plan already in place. Regular updates on the action plan are submitted to the Workforce Committee, who will monitor progress and implementation against the action plan.

Between October and December 2017 the Trust carried out a census survey to ensure all staff had the opportunity to express their views. 2434 members of staff completed the survey (43%).

The results of the staff survey in 2017 have shown that staff are able to contribute to improvements at work and we have low incidences of staff experiencing discrimination at work. There is a better than average score for staff satisfaction; satisfaction with the quality of work and care staff are able to deliver; and staff confidence and security in reporting unsafe clinical practice. Staff recommending the Trust as a place to work or receive treatment scored as below average.

In 2018 we intend to focus on initiatives to improve the quality of our appraisals and provide staff with tools and techniques to improve their health and wellbeing.

Response rate

	2016*	2017		Trust Improvement/ deterioration
	Trust	Trust	Trust Type Average	
Response rate	45%	43%	44%	Decrease of 2% points

Top 5 ranking scores

	2016*	2017		Trust
	Trust	Trust	Trust Type Average	
KF11. Percentage of staff appraised in last 12 months	87%	95%	86%	Improvement
KF22. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months	16%	13%	15%	Improvement
KF7. Percentage of staff able to contribute towards improvements at work	73%	72%	70%	No change
KF20. Percentage of staff experiencing discrimination at work in the last 12 months	8%	11%	12%	No change
KF26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	24%	23%	25%	No change

Bottom 5 ranking scores				
	2016*	2017		Trust Improvement/ deterioration
	Trust	Trust	Trust Type Average	
KF18. Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	53%	57%	52%	No change
KF17. Percentage of staff feeling unwell due to work related stress in the last 12 months	46%	43%	36%	Deterioration
KF19. Organisation and management interest in and action on health and wellbeing	3.46	3.47	3.62	No change
KF12. Quality of appraisals	3.00	2.99	3.11	No change
KF32. Effective use of patient / service user feedback	3.73	3.61	3.71	Deterioration

Key area of improvement				
	2016*	2017		Trust Improvement/ deterioration
	Trust	Trust	Trust Type Average	
KF11. Percentage of staff appraised in last 12 months	87%	95%	86%	Improvement

*The 2016 survey was from a sample size of 800 colleagues. The 2017 survey was a census of all colleagues.

Investors in People (IIP)
The Trust currently holds the IIP Bronze Award, awarded in December 2015.

The Trust was assessed in September 2017 as year 2 of a three-year 'staged assessment process'. The indicative outcome findings at this stage supported many areas where the organisation had received internal feedback through its surveys, audits, internal inspections and external feedback through the CQC Inspection and staff and patient friends and family tests, all of which will inform and contribute to further internal planning and improvements. The final assessment will take place in 2018.

Future priorities and targets
A key principle in the staff engagement approach will be to work with local teams and networks to help colleagues address issues in their own area. A working group has begun work on the 2017 Staff Survey results. The approach embraces the four pillars of CHFT such as 'Go See' to teams which have more positive results, in order to learn.

Local teams will be supported with resources such as session plans, frequently asked questions, and demonstrations of how to run a colleague focus group. The Trust's Colleague Engagement Network, and Black and Asian Minority Ethnic (BAME) Network will be involved. A communications plan is to be devised which will include easy-to-understand 'infographic' of results for each area.

Learning and outputs will be monitored and overseen by the Trust's Workforce Committee.

Colleague engagement

We know that effective staff engagement and communication is essential in designing and delivering high quality services to meet current and future challenges as well as the diverse needs of the people who use our services. We believe that colleagues are more likely to be motivated and experience higher levels of job satisfaction when they receive fair treatment, opportunity for development, involvement in the decision-making process and good management and support from effective leaders.

Through our values and behaviours, alongside the development of our workforce, we aim to improve capability and capacity for transformational change. This is underpinned by delivering effective appraisals focused on personal and professional development to continuously improve our performance against the Investors in People Standard which we will be formally assessed against during 2018. The Trust recognises that improving and sustaining levels of job satisfaction, colleague engagement and colleague health and wellbeing is key to its ability to deliver transformational change; and that given the scale of that change, this presents a real challenge and as such is a top priority requiring focussed leadership and grip across the organisation. Formal engagement takes place with staff side representatives through the Staff Management Partnership Forum which meets on a monthly basis and the Medical and Dental Pay and Conditions Committee. We have six elected staff members on our Membership Council, all of whom are active in engaging with employees of the Trust as Foundation Trust Members and ensuring that they are involved in developing the work of the Trust. The Trust has established colleague engagement and Black, Asian and Minority Ethnic colleague networks for the purposes of informing, testing and communicating its approach to improving the colleague experience as employees. More generally, we engage with our workforce directly through a range of channels and mechanisms that promote engagement, communication and information share including:-

- Team Brief on a monthly basis, which ensures all staff receive regular updates from the Board of Directors and Executive Board meetings as well as Divisional and Departmental updates
- CHFT Weekly, an electronic newsletter for staff sharing top news stories for the week which provides a lively mixture of service, performance and financial information as well as items about individual, team and Trust achievements
- Our staff intranet has been refreshed and relaunched to provide better access and improved design and content
- A monthly briefing session 'Big Brief' led by Board Directors and open to all colleagues
- Team meetings, briefing sessions, workshops and meetings which involve the Chief Executive and other members of the Executive Team
- Colleagues have access to the Chief Executive through his blog communication, which allows for an exchange of views on specific issues. There is also an opportunity for staff to meet face-to-face with the Chief Executive through scheduled sessions to find out 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
- A Freedom to Speak Up Guardian and a well-established raising concerns policy
- Executive Directors and senior staff visit clinical areas and departments to meet with colleagues and give them the opportunity to raise any workplace issues
- The 'Ask Owen' facility provides an opportunity for colleagues to raise issues directly with the Chief Executive with questions and answers available to all staff through the intranet
- An appraisal season during which a line manager and direct report can engage in meaningful conversation about development needs as well as performance
- A Workforce and OD Line Manager Bulletin is published monthly to with a focus on developing/enhancing a manager toolkit that is informative, educational and practical for colleagues dealing with day to day workforce/employee issues in the Trust.

Our workforce strategy

The Trust has a 5-year workforce strategy which draws together the approaches required to attract, retain, support, engage and reward our people as we develop and reconfigure services. The operational, clinical and system wide challenges confronting the Trust are faced in a continuing difficult financial environment for health and social care. It is in this context that the Trust is looking to reshape its workforce, building 'a workforce of the right size and shape with the commitment, capability and

capacity to deliver safe, efficient, high quality patient care within the available resource'. The workforce strategy sets out a vision for an engaged and healthy organisational culture supported by a sustainable and capable workforce working in an integrated and coordinated approach with our partners. This requires us to ensure that we lead and manage in a manner which firmly demonstrates a commitment to our values and behaviours – and that we put these into action through everything we do. The strategy captures activity in relation to recruitment, retention, workforce planning, agency spend, attendance management, colleague engagement and organisation development and leadership. We are working towards ensuring:-

- Colleagues are clear about the Trust's priorities, feel valued, confident that their voice is heard; and able to take an active part in decisions which affect the Trust, its patients, carers and the community.
- Colleagues are value driven and work together in pursuit of Trust priorities; the right teams are in the right place at the right time collaborating to deliver safe, efficient, high quality patient care within the available resource.
- Colleagues are professional and capable, feel equipped to make an effective contribution to Trust priorities and are actively supported by a directive and inclusive leadership community.
- Colleagues are resilient, feel supported to improve and maintain their health and wellbeing, sustaining their availability for work to the benefit of patients and fellow team members.
- Colleague development will be supported by focus upon the Investors in People standards and will be underpinned by delivery of an effective appraisal. We will continue to strive for improvement utilising the Investors in People Standard as a key approach for driving and analysing our delivery.

In 2017/2018, we established and ran the Compassionate Leadership in Practice (CLIP) development programme as well as programmes for Band 6 Theatre staff, Band 7 Nurses, Ward Managers and Matrons. In addition, a Preceptorship Development Programme for Newly Qualified Nurses is in place. We support Black, Asian and Minority Ethnic (BAME) colleagues through an established network and introduced an inclusive mentoring programme. We have increased the number of apprenticeships in clinical and non-clinical roles as we grow our future workforce and are looking to further enhance coverage in the next year as we support the development of the existing workforce. We have been successful in our recruitment activity with significant improvements made to our recruitment processes and the applicant/recruiting manager experience – time to hire has reduced by more than 50%. Good progress has been made in recruiting skilled employees particularly to Consultant posts. Additionally, Physician Associates are now in place and a formal programme to support medical to colleagues obtain Consultant status has been established.

We continue to provide positive support to people with a disability who wish to secure employment with the Trust through the Guaranteed Interview scheme and comply with 'two ticks' requirements. We are recognised as a Disability Confident employer. There are policies in place which support staff who may become disabled during their employment.

A Workforce Committee chaired by a Non- Executive Director and reporting to the Board of Directors, is in place and works to secure assurance that focus is maintained on workforce issues and that progress is being made in implementing the strategy.

Colleague health and wellbeing

The wellbeing of our employees 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. The Occupational Health team's primary objective is to promote and support the health and wellbeing of all colleagues working for the Trust, with specific regard to the relationship between health and work. Its aim is to keep staff healthy and happy in work and by doing so, to protect and ensure the best possible service to patients.

The service is Safe Effective Quality Occupational Health Standards (SEQOHS) accredited and has been since December 2013. The Standards measure that the Occupational Health Department meets minimum requirements, reflecting existing ethical and professional guidance and consensus and helps them achieve uniform good practice. The service has a strong focus on the health and well-

being of colleagues and is working with local partnerships and networks to focus on initiatives such as colleague wellbeing support for staff and managers on mental health pathways and reducing the impact of musculoskeletal conditions. A five year wellbeing strategy has been co-created with colleagues and captures the key areas for attention and development. In addition, there is a CQUIN for wellbeing which frames our activity around organisational care for the wellbeing of colleagues, improved mental health awareness and training and reducing incidents of back pain. This included a 70.45% take-up of the flu vaccine by colleagues in the Autumn/Winter of 2017 and improvements in the provision of healthy food options in all of the Trust's on-site retail and catering facilities have been maintained. 2017 also saw the planting of our first wellbeing garden at the Calderdale Royal Hospital site and the creation of a gardening staff group for staff to join and help maintain this tranquil and edible garden, and the creation of a garden on the Huddersfield Royal Infirmary site. The Trust distributed its wellbeing handbook co-created by colleagues and featuring guidance and signposting for many of the wellbeing opportunities for staff. The handbook is also available on the intranet. A wellbeing active mobile phone app continues to be available to all staff and their families, with helpful tips on keeping well and getting active. The Trust supports physical activity and its annual Men's Health Football event, held in autumn 2017 again proved popular. It is planned to continue with this in 2018.

- Mental Wellbeing

A policy has been published which describes the support available to managers and staff in managing mental wellbeing at work. This includes information on access to support services available such as:-
– in house confidential counselling
– bespoke training for staff and managers on managing stress, promoting mental wellbeing and undertaking stress risk assessments
– Mental Health First Aid training
– mindfulness training programme.

- Musculoskeletal Pain

In conjunction with colleagues in physiotherapy intranet information and self- help treatment information and training has been published on the intranet. A direct referral to physiotherapy service is available to colleagues through the occupational health.

- Physical activity and wellbeing

An intranet wellbeing programme has been enhanced and is available to all staff, incorporating a mobile phone wellbeing application, also available to their families and friends. A network of champions has been established and is growing, to support local engagement and leadership on a particular health interest or in a geographical area, and to promote the health and wellbeing messages.

Attendance Management

The Trust's sickness absence rate for 2017/2018 was 4.09%.

Average 2017 full time equivalent staffing	5260
Adjusted days lost	48,282
Average sick days per full time equivalent	9.2

The Trust recognises that the health and wellbeing of its employees is a key determinant of safe and high quality services. It is an essential feature of its Board approved workforce strategy. 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. In addition, colleagues are telling us that we can do more to support their health and wellbeing. In this regard, the Trust is continuing to focus attention in this area working with colleagues to ensure that it responds appropriately.

Appraisal and development

Following a successful first appraisal season in from July to October 96% of colleagues met with their line manager for a conversation about their development needs opportunities and their contribution to the work we do. We are continuing with the approach in 2018/2019 with an appraisal season starting in April. We recognise improvements to the appraisal experience are required and we are working towards this. Mandatory training remains a key focus and we delivered >95% compliance in the last year.

The training programme, which largely comprises e-learning, enables the Trust to demonstrate that employees regularly have mandatory training designed to ensure they can undertake their job roles safely and maintain a safe and healthy work environment. The Trust's approach identifies what training employees are required to complete, how often they are required to complete the training and how to access the training.

Trade Union (Facility Time Publication Requirements) Regulations 2017

There is a requirement to report trade union facility time in accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017 in the annual report and on the website. The deadline is the end of July and there is some work for us to complete before publication so this is the text proposed for the annual report:-

'Trade Union (Facility Time Publication Requirements) Regulations 2017

The Trust is required to publish information under these Regulations and this will be available by 31 July 2018 on its website.'

Medical Education

In 2017 we recruited our first cohort of 13 Physician Associates (across medicine and surgery) and are in the process of developing a robust faculty.

Once again we achieved a 100% response rate to the GMC Doctor in Training Survey. We scored best in region for overall satisfaction for Acute Internal Medicine (2nd year in a row), Orthopaedics, Emergency Medicine Foundation Year 1 (2nd year in a row) and Emergency Medicine GP Specialty Trainees.

We have had a very successful year in terms of hosting medical education and skills courses for internal and external staff and users:

- We hosted another very successful Mock OSCE (Observed Structured Clinical Examination) for the Leeds Medical School 5th year medical students. We also organised our very first Mock OSCE event for the Physician Associate students which proved very popular and was well received by the students
- We continued to link with local schools and sixth form colleges and hosted our interactive 'So you want to be a doctor?' event where sixth form students have the opportunity to meet with medical students and a range of different grades of doctors across different specialties as well as gain some important tips for applying to medical school.
- We extended our training portfolio by offering library skills sessions in conjunction with colleagues with the University of Huddersfield to support their MSc students, The Research and Development Department by facilitating critical appraisal sessions and by offering sessions for newly qualified and overseas nurses via the Clinical Education team.
- The simulation team were successful in securing the funding following a successful bid to HEE to purchase a Wi-Fi birthing manikin and part task trainers specific to support the current PROMPT (Obstetrics and gynaecology) training course and development of a new course, Deteriorating Obstetric Patients. The Simulation team were instrumental in the set-up of this new course, advising on the best way forward arranging the dates and recruiting faculty.

Volunteers

Volunteers play a pivotal role in the smooth running of our hospital. There are currently more than 400 volunteers working between Calderdale Royal Hospital and Huddersfield Royal Infirmary. Many of the Trust volunteers have been with us for a number of years and work in various departments helping with administration, making teas and coffees for patients and visitors, assisting on the wards along with meeting and greeting in the main entrances. All volunteers undertake pre-employment checks and are fully inducted into the Trust to ensure they are aware of confidentiality, health and safety and infection control. Current volunteers have 98% Compliance on DBS and 96% on mandatory training where last April it was zero.

Disclosures set out in the NHS Foundation Trust Code of Governance

Calderdale and Huddersfield NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The purpose of the code of governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice, but requires a number of disclosures to be made within the annual report.

The NHS Foundation Trust Code of Governance contains guidance on good corporate governance to NHS foundation trusts to help them deliver effective corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients. NHS Improvement, as the healthcare sector regulator and the code's author, is keen to ensure that NHS foundation trusts have the autonomy and flexibility to ensure their structures and processes work well for their individual organisations, whilst making sure they meet overall requirements. For this reason, the code is designed around a "comply or explain" approach.

Comply or explain

NHS Improvement recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for non-compliance with the code should be explained. This "comply or explain" approach has been in successful operation for many years in the private sector and within the NHS foundation trust sector. Trusts are required to assess their compliance with the Code and explain any departures to NHS Improvement. In providing an explanation for non-compliance, NHS foundation trusts are encouraged to demonstrate how its actual practices are consistent with the principle to which the particular provision relates.

Whilst the majority of disclosures are made on a "comply or explain" basis, there are other disclosures and statements (which we have termed "mandatory disclosures" in this report) that we are required to make, even where we are fully compliant with the provision.

As a licensee, the Trust is required to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. To do this, the Trust has regard to guidance from NHS Improvement, the sector regulator for healthcare, including the NHS Foundation Trust Code of Governance. All directors and Council of Governors have signed a declaration indicating their compliance with the "fit and proper persons" test introduced through condition G4 of the provider licence.

There are a number of key policies and documents that capture the main and supporting principles of the Code:

- Standing Orders, Standing Financial Instructions, Scheme of Delegation and Constitution.
- Standards of Business Conduct and Register of Declarations of Interest
- Integrated Board Report
- Board and Committee reports and the supporting minutes
- Annual business cycle of the Board of Directors and its Committees
- Risk Management Policy and Procedure
- Job description and role description of the Senior Independent Director
- Terms of reference of the committees and sub-committees of the Board of Directors and Membership Council
- The Board of Directors skills and capabilities matrix
- Non-Executive Director candidate information pack and induction programme
- Appraisal policy
- Well-led Governance Review report
- Council of Governors standing orders
- Council of Governors' Charter
- Membership Strategy and Policy for Engaging Members
- Membership Councillors Recruitment and Induction Pack
- Policy for the expulsion of Membership Councillors
- Chairs' Information Exchange
- Internal and External Auditor reports
- Fit and Proper Person Annual Self-declaration

The Trust reviewed its governance arrangements in light of the code and makes the following statements:

Directors

The Trust is headed by a Board; it exercises its functions effectively, efficiently and economically. The Board is a unitary board consisting of a non-executive chair, seven non-executive directors and seven executive directors. Full details of members of the Board can be found on p28 including changes to the membership of the board during 2017/18.

The Board provides active leadership within a framework of prudent and effective controls and monitors compliance with the terms of its licence. The Board meets a minimum of nine times a year so that it can regularly discharge its duties.

The non-executive directors hold executive directors accountable through scrutiny of performance outcomes, management of business process systems and quality controls, and satisfy themselves as to the integrity of financial, clinical and other information. Financial and clinical quality control systems of risk management are robust and defensible.

In addition, members of the Board undertake an annual personal skills and knowledge assessment. The proposition for this assessment is that the Board can regard itself as competent if there is a good spread of in depth and working knowledge for each domain across the Executive Directors and Non-Executive Directors. This assessment is used to satisfy the Board that it is fit for purpose and to inform recruitment processes to ensure that any gaps that arise at short notice, or can be predicted through turnover, are filled.

The non-executive directors, through the Nomination and Remuneration Committee, fulfil their responsibility for determining appropriate levels of remuneration of executive directors. The Committee is provided with benchmark data to support the decision being made about the level of remuneration for the executive directors. More details about the Nominations and Remuneration Committee can be found on p65.

Annually the Board reviews the strategic aims and takes responsibility for the quality and safety of healthcare services, education, training and research. Day-to-day responsibility is devolved to the executive directors and their teams. The board of directors is committed to applying the principles and standards of clinical governance set out by NHS England, the Department of Health and the Care Quality Commission. As part of the planning exercise the Board of Directors reviews its membership and undertakes succession planning.

The Board of Directors has reviewed its values and standards to ensure they meet the obligations the Trust has to its patients, members, staff and other stakeholders.

The appointment of the Chair and Non-Executive Directors forms part of the information included in the standing orders written for the Council of Governors. Each year the Chair and Non-Executive Directors receive an appraisal which is reviewed by the Council of Governors. The Chair undertakes an appraisal on the Chief Executive and the Chief Executive undertakes the appraisal of the Executive Directors. Details of the approach to appraisals can be found on p81 of this report.

The Chair

A clear statement outlining the division of responsibility between the Chair and the Chief Executive has been approved by the Board of Directors.

Governors

The Trust has a Council of Governors which is responsible for representing the interests of the members of the Trust, partner, voluntary organisations within the local health economy and the general community served by the trust. The Council of Governors holds the non-executive directors individually and collectively to account for the performance of the Board of Directors, including ensuring that the Board of Directors acts within the terms of the licence. Governors feedback information about the Trust to members and the local community through a regular newsletter and information placed on the Trust's website.

The Council of Governors consists of elected and appointed councillors. More than half are public governors elected by community members of the trust. Elections take place once every year or on other occasions if required due to vacancies or a change in our constitution. The next elections will be held during summer 2018.

The Council of Governors has in place a process for the appointment of the Chair which includes understanding the other commitments a prospective candidate has.

Information, development and evaluation
The information received by the Board of Directors and the Council of Governors is timely, appropriate and in a form that is suitable for members of the Board and Council to discharge their duty.

The Trust runs a programme of development throughout the year for Governors and Non-Executive Directors. All Governors and Non-Executive Directors are given the opportunity to attend a number of training sessions during the year.

The Council of Governors has agreed the process for the evaluation of the Chair and Non-Executive Directors and the process for appointment or re-appointment of the Non-Executive Directors.

The Chair, with the support of the other Non-Executive Directors, reviews the performance of the Chief Executive as part of the annual appraisal.

The Chief Executive evaluates the performance of the Executive Directors on an annual basis and the outcome is reported to the Chair. The Chair provides the Chief Executive with his view of the Executive Directors' performance in the board meeting.

Performance evaluation of the board and its committees
During the year the members and attendees of each of the committees undertake a self-assessed evaluation of the committee's effectiveness against compliance with the terms of reference and the annual work plan. The results of the self-assessment form a development plan for the committee over the year.

The feedback from the CQC Well Led and Use of Resources inspections once received will form part of the development plan for 2018/19.

Resolution of disputes between the Council of Governors and the Board of Directors
The code of governance requires the Trust to hold a clear statement explaining how disagreements between the Council of Governors and the Board of Directors would be resolved.

The Board of Directors promotes effective communications between itself and the Council of Governors. The Board, through the Chief Executive and the Chair, provide regular updates to the Council of Governors on the developments being undertaken in the Trust. The Board encourages the governors to raise questions and concerns during the year and ask for further discussions at their public meetings where they feel further detail is required. The Chief Executive and any invited director or Non-Executive Director will ensure that the Governors are provided with any information when the financial standing of the trust has materially changed the or the performance of its business has changes or where there is an expectation as to performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, health care delivery performance or reputation and standing of the Trust.

The Chair of the Trust also acts as chair of the Council of Governors. The chair's position is unique and allows him to have an understanding of a particular issue expressed by the Council of Governors. Where a dispute between the Council of Governors and the board occurs, in the first instance, the chair of the trust would endeavour to resolve the dispute.

If the Chair is not willing or able to resolve the dispute, the Senior Independent Director and the lead governor of the Council of Governors would jointly attempt to resolve the dispute.

In the event of the Senior Independent Director and the lead governor were not being able to resolve the dispute, the board of directors, pursuant to section 15(2) of Schedule 7 of the National Health Service Act 2006, will decide the disputed matter.

Governors also have the right to refer concerns to NHS Improvement the sector regulator in exceptional circumstances where the internal mechanisms have not satisfied the Council of Governors concern. The Council of Governors also has the right to seek the advice of NHS Improvement's Independent Panel.

The Board makes decisions about the functioning of the Trust and where appropriate consult with the Council of Governors prior to making a decision. Any major new development in the sphere of activity of the trust which is not public knowledge is reported to the Council of Governors in private session and to NHS Improvement.

The Council of Governors is responsible for the decisions around the appointment of the non-executive directors, the appointment of the external auditors in conjunction with the Audit and Risk Committee, the approval of the appointment of the chief executive and the appointment of the Chairman. The Council of Governors set the remuneration of the non-executive directors and Chairman. The Council of Governors are encouraged to discuss decisions made by the Trust and highlight any concerns they have. The Council of Governors also has in place a statement that identifies at what level the Board of Directors will seek approval from the Council of Governors when there is a proposed significant transaction.

Understanding the views of membership councillors and members

Directors develop an understanding of the views of the Council of Governors and members about the organisation through attendance at members' events, council of governors' meetings, and attending the annual members' meeting. The directors also hold a joint workshop with the governors twice a year.

Board balance, completeness and appropriateness

As at year ending 31 March 2018, the Board of Directors for Calderdale and Huddersfield NHS Foundation Trust comprised of seven Executive Directors, seven Independent Non-Executive Directors and an Independent Non-Executive Chairman.

Appraisal of board members

The Chairman has conducted a thorough review of each Non-Executive Director to assess their independence and contribution to the Board of Directors and confirmed that they are all effective independent Non-Executive Directors. A programme of appraisals has been run during 2017/18 and all Non-Executive Directors have undergone an annual appraisal as part of the review.

The appraisal of the Chief Executive is undertaken on an annual basis by the Chair in line with the Trust's revised appraisal process which was first introduced in 2014.

The Board of Directors maintains a register of interests as required by the constitution and Schedule 7 section 20 (1) National Health Service Act 2006 published at www.cht.nhs.uk.

The Board of Directors requires all Non-Executive Directors to be independent in their judgement. The structure of the Board and integrity of the individual Directors ensures that no one individual or group dominates the decision-making process.

Each member of the Board of Directors upholds the standards in public life and displays selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

All Board members have confirmed that they are fit and proper persons to hold the office of Director in the Trust and have no declarations to make that would be contrary to the requirements. All Board members have confirmed that they do not hold any additional interests that are not declared in the Trust's Declaration of Interest.

The Board, in relation to the appointment of Executive Directors, has an annual meeting of the Nominations and Remuneration Committee which can be convened at other times if required.

Biographies for the Board of Directors can be found on p32 of this report.

Internal audit function

The Trust has an internal audit function in place that provides support to the management of the organisation. Details of the internal audit function can be found on p41.

Attendance of non-executive directors at the council of governors

All Non-Executive Directors have an open invitation to attend the council of governors' meetings. In addition Non-executive directors are required to attend on a rotational basis. The Trust has also arranged for the board of directors and the governors to participate in two workshops during the year focussing on the development of strategy and the performance of the Trust.

Governors and Non-Executive Directors work together on other occasions through various groups and committees and meet on a one-to-one basis during the year.

Corporate Directors' remuneration
The Nomination and Remuneration Committee meets on a regular basis and as a minimum once a year to review the remuneration of the corporate directors. Details of the work of the Nominations and Remuneration Committee can be found on p57. The Council of Governors has a Nominations and Remuneration Committee which meets as required during the year. Part of the role of this Committee is to review the remuneration of the non-executive directors. Details of the Council of Governors Nomination and Remuneration Committee can be found on p81.

Accountability and audit
The Board of Directors has an established Audit and Risk Committee that meets on a quarterly basis, as a minimum. A detailed report on the activities of the Audit and Risk Committee is on p36.

Relations and stakeholders
The Board of Directors has ensured that there is satisfactory dialogue with its stakeholders during the year. Examples of the Trust working with stakeholders can be found on p48.

Mandatory disclosures

Code provision	Requirement	Location in Annual Report
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Accountability Report P30
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Accountability Report Pages 50 and 81
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability Report P76
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Accountability Report p30
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Accountability Report P30
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Accountability Report Pages 30 and 32
FT ARM*	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Accountability Report P30
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability Report P50
FT ARM*	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	No other significant commitments to report

Code provision	Requirement	Location in Annual Report
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report P91
FT ARM*	If, during the financial year, the Governors have exercised their power to require one or more of the directors to attend a meeting for the purpose of providing information about the Trust's performance of its functions or the directors' performance of their duties, then information on this must be included in the annual report.	N/A
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability Report P30
B.6.2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	Performance Report N/A
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Accountability Report Pages 40 and 101
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Accountability Report P94
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Accountability Report P40
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	N/A

Code provision	Requirement	Location in Annual Report
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: – the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; – an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and – if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Accountability Report P40
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Accountability Report P68
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report P76
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Accountability Report P82
FT ARM*	The annual report should include:	
	– a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; – information on the number of members and the number of members in each constituency; and – a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Accountability Report P82
FT ARM*	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	Accountability Report P80

*FT ARM disclosures are required by the NHS Foundation Trust Annual Reporting Manual rather than the code of governance.

NHS foundation trusts are public benefit corporations and it is considered to be best practice for the annual report to include "public interest disclosures" on the foundation trust's activities and policies in the areas set out below:

Summary of disclosure required	
Actions taken to maintain or develop the provision of information to, and consultation with, employees;	P60
The foundation trust's policies in relation to disabled employees and equal opportunities;	P60
Information on policies and procedures with respect to countering fraud and corruption;	P40
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998	P40
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	N/A
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Accounts
A statement that the NHS foundation trust has complied with the cost allocation and charging guidance issued by HM Treasury	Accounts
Details of serious incidents involving data loss or confidentiality breach	Annual Governance Statement

Voluntary disclosures

The "voluntary disclosures" (as defined by the foundation trust annual reporting manual) have also been covered in this annual report. These can be found as follows:

Summary of disclosure	
Sustainability reporting	Performance Report p25
Equality reporting	Accountability Report p106
The NHS Constitution	Accountability Report p106

Our Membership Council

In June 2017 the Trust's "Membership Council" was renamed and became the Council of Governors (CoG).

Governors have an important role in the governance and accountability of the Trust. They help to hold us to account for the decisions that are made about patient services, and bring the 'eyes and ears' of the lay person into discussions about developing those services in the future.

The CoG comprises 16 publicly elected, six staff elected and six nominated stakeholder governors. Governors are broadly representative of the population that the Trust serves. They listen to the views and ideas of the Trust's membership and of the wider public. In turn, the Trust offers a range of events and opportunities for the governors to share those views and engage with the board of directors in order to influence strategy and develop services for patients.

The CoG has selected a lead governor who is also the Deputy Chair. The lead governor is currently Brian Moore. The Chair of the Trust is the Chair of the Council of Governors.

Elections

In order to refresh the Membership Council and bring a diverse range of views into the Trust, elections are held every year. These elections are held in the various geographical or staff constituencies of the Trust. During 2017 the following elections were made with each member being offered a 3 year term with effect from 15 September 2017:-

CONSTITUENCY	NAME	RE-ELECTED/ELECTED	ELECTION TURNOUT
Constituency 3	Mr John Richardson	Elected unopposed	Unopposed – N/A
Constituency 5	Mr Brian Richardson	Elected	Turnout 14.6%
Constituency 6	Mr Paul Butterworth	Elected unopposed	Unopposed – N/A
Constituency 7	Miss Alison Schofield	Elected	Turnout 7.9%
Constituency 7	Mrs Lynn Moore	Elected	Turnout 7.9%
Constituency 9	Dr Peter Bamber	Elected	Turnout 18.3%
Constituency 11	Mrs Linzi Smith	Elected unopposed	Unopposed – N/A
Constituency 12	Mrs Theodora Nwaeze	Elected Unopposed	Unopposed – N/A
Constituency 13	Miss Sian Grbin	Elected	Turnout 8%

Governors and the Trust working together

Governors get to know and understand the business of the Trust through their involvement in a range of committees and groups. These help governors to hold the non-executive directors to account for the performance of the Trust, and help the non-executive directors to develop an understanding of the views of governors. These committees and groups are:

Council of Governor (CoG) meetings

There are four CoG meetings per year, plus the Annual General Meeting. Board directors are invited to attend and report on standing agenda items such as business planning, service developments, quality and the Trust's financial position. Non-executive directors attend as observers. The CoG receives the Integrated Board Report at each of its meetings presented by the Chief Operating Officer, the Director of Finance, and the Director of Nursing.

Trust Board meetings
Two governors are invited to attend each monthly Trust board meeting to act as observers. An opportunity is given to governors to share any comments or observations.

Trust board sub-committees
Governors sit on each of the sub-committees of the Trust board. These are: Finance & Performance; Audit & Risk; Charitable Funds; Quality and the Workforce Well-led committees.

Divisional Reference Group meetings
Divisional Reference Group meetings take place three times per year. They are attended by the senior management team of the respective division and a selection of governors, and they are chaired by a governor. These meetings give governors the opportunity to ask questions of senior clinical and managerial Trust colleagues, and challenge decisions as necessary. Divisional plans and performance are discussed, along with compliments and complaints, staffing and clinical issues.

Chairs' Information Exchange meetings
The Trust chairman is informed of the discussions and decisions of the Divisional Reference Groups by the Chair of each group at the regular Chairs' Information Exchange meetings. During the second half of the meeting, to which staff governors are also invited, the chairman updates the governors on Trust issues and priorities. This information exchange helps to inform the agenda of both the CoG meetings and the Trust board meetings.

Attendance at Membership Council meetings – 2017-18

MEETING DATES		5.4.17	6.7.17	20.7.17 AGM	26.10.17	23.1.18	TOTAL ATTENDANCE
PUBLIC – ELECTED							
1	Mrs Rosemary Claire Hedges	√	√	x	x	√	3/5
1	Mrs Di Wharmby	√	x	x	x	√	2/5
2	Mrs Veronica Maher	√	√	√	x	x	3/5
2	Mrs Katy Reiter	x	x	x	x	x	0/5
3	Mr Peter John Middleton	√	√	√	Tenure ceased 14.9.17	-	3/3
3	Mr John Richardson	-	-	x Tenure commenced 15.9.17	x	x	0/3
3	Ms Dianne Hughes	√	x	√	x	x	2/5
4	Mrs Nasim Banu Esmail	x	x	x	x	x	0/3
4 *							
	Mr Grenville Horsfall	x	x	x	Tenure ceased 14.9.17	-	0/3
4 +	Ms Kate Wileman	√	√	√	x	x	3/5
5	Mr George Edward Richardson	√	√	√	Tenure ceased 14.9.17	-	3/3
5	Stephen Baines	√	x	x	√	x	2/5
5	Mr Brian Richardson	x	x	√	x	x	1/5
6	Mrs Annette Bell	√	√	√	√	√	5/5
6	Mr Paul Butterworth			x Tenure commenced 15.9.17	√	√	2/2
7	Mrs Lynn Moore	√	√	√	√	x	4/5
7	Miss Alison Schofield			x Tenure commenced 15.9.17	√	√	2/2
8	Mrs Michelle Rich	x	x	x	x	x	0/5
8	Mr Brian Moore	x	√	√	√	√	5/5
STAFF – ELECTED							
9 - Drs/ Dentists	Dr Mary Kiely	x	x	x	Tenure ceased 14.9.17	-	0/3
9 - Drs/ Dentists	Dr Peter Bamber			x Tenure commenced 15.9.17	√	x	1/2
10 - AHPs/ HC/Pharm's	Mrs Nicola Sheehan	x	x	x	x	Leaves 24.11.17	0/4

MEETING DATES		5.4.17	6.7.17	20.7.17 AGM	26.10.17	23.1.18	TOTAL ATTENDANCE
11 - Mgmt/ Admin/Clerical	Mrs Linzi Smith	-	-	x Tenure commenced 15.9.17	√	√	2/2
12 - Ancilliary	Theodora Nwaeze	-	-	x Tenure commenced 15.9.17	x	x	0/2
13 - Nurses/ Midwives	Sian Grbin	-	-	x Tenure commenced 15.9.17	x	√	1/2
13 - Nurses/ Midwives	Charlie Crabtree	x	x	x	x	x	0/5
NOMINATED STAKEHOLDER							
University of Huddersfield	Dr Cath O'Halloran	x	- Tenure ceased 14.6.17	-	-	-	0/1
University of Huddersfield	Graham Ormrod		√ Tenure comm. 15.6.17	x	x	Tenure ceased 1.1.18	1/4
University of Huddersfield	Felicity Astin	-	-	-	-	√	1/1
Calderdale Metropolitan Council	Cllr Bob Metcalfe	√	√	√	Tenure ended 3.10.17	-	3/3
Calderdale Metropolitan Council	Cllr Megan Swift			Tenure commenced 3.10.17	√	√	2/2
Kirklees Metropolitan Council	Vacant Post	-	-	-	-	-	-
Clinical Commissioning Group	David Longstaff	x	x	x	Tenure ended 2.10.17		0/3
Locala	Sharon Lowrie	x	x	x	x		0/5
Locala	Chris Reeve					x	0/1
South West Yorkshire Partnership NHS FT	Salma Yasmeen	-	-	-	x	x	0/2
South West Yorkshire Partnership NHS FT	Dawn Stephenson	x	√	x Tenure ceased 6.7.17	-	-	1/2
HealthWatch Kirklees	Mr Rory Deighton			Tenure commenced 2.10.17	√	x	1/2

* Reserve Register from 15.9.16
+ Reserve Register cons 4 from 15.9.17 previously cons 5

Governor training and development

In order for its governors to discharge their duties, the Trust provides a range of training and development offerings. These are:

Governor Induction
All newly-elected or appointed governors are invited to attend a comprehensive induction process. This consists of presentations, discussion, provision of information and Trust guest speakers. Attended by the chairman, this induction introduces governors to the structure, services and strategy of the Trust; and it clarifies their role in terms of governance and accountability. It marks the beginning of the process of governors becoming familiar with and engaging in the development of Trust plans and services.

Governor Training Programme
The Trust offers a range of optional training opportunities throughout the year. These take the form of two-hour sessions which allow governors to learn about the systems and processes of the NHS and of the Trust. The sessions support our governors to feel more confident in their duty to hold non-executive directors to account for the performance of the board. These interactive and informative sessions cover such topics as 'Understanding Quality in the NHS & Patient Experience', 'An Introduction to NHS Finance' and 'Holding to Account'.

CoG Development Days
In addition to the training sessions, the Trust has a programme of CoG development sessions. These are held throughout the year and are attended by governors, the Trust chairman and board directors. The content of these sessions typically includes guest speakers, information items and group exercises where governors can explore healthcare topics in more depth. An 'open space' discussion is always included allowing governors to debate current key challenges and opportunities. These debates and discussions help to shape future Trust plans.

Understanding Governors' views

Non-executive directors develop an understanding of the views of governors through a variety of mechanisms. This helps to contribute to the good governance of the Trust and include:

Chairman's One-to-One meetings
The Trust chairman meets quarterly with the deputy chairman of the CoG for an exchange of views and an update on current topics. In addition, each newly-elected or appointed governor is offered the opportunity to meet with the Trust chairman on a one-to-one basis. These meetings help to set expectations and clarify the role of the CoG/the governors and the support available to them.

Joint workshops with directors and non-executive directors
Governors meet with the full board of directors at a workshop twice a year. These workshops enable all parties to both look back and review progress on key developments and to look forward and jointly plan future strategic initiatives. Governors also meet separately twice yearly with just the non-executive directors. These workshops allow everyone to learn about their respective roles, and share with each other their knowledge about, and involvement in, the Trust's services.

Approval of Annual Plan
Governors are asked to consider and comment upon proposals for the Trust's forward plan. An extraordinary CoG meeting is called for this purpose and discussions from the Divisional Reference Group meetings are used to inform this process. Following this discussion, and with the agreement of the CoG, proposals are then submitted to the board for final approval.

Expenses claimed by Governors during 2017/18
Governors do not receive payment for their work with the Trust. However we do have a policy for re-imbursement of any necessary expenditure while on Trust business at a rate of 0.28p per mile. During 2017/8 the following expenses were claimed:

	2016/17	2017/18
Total number of Governors	15	25
Total number of claiming expenses	8	8
Total amount of expenses claimed	£708.91	£1,388.06

Related party transactions

Under International Accounting Standard 24 'Related Party Transactions', the Trust is required to disclose, in the annual accounts, any material transactions between the NHS Foundations Trust and members of the Council of Governors or parties related to them.

There were no such transactions for the period 1 April 2017 to 31 March 2018.

Register of Membership Councillors' interests
All Governors have a responsibility to declare relevant interests as declare relevant interests as defined in our Constitution. These declarations are made to the Board Secretary and are reported to the Council and entered into a register.
The public can access the register at www.cht.nhs.uk or by making a request in writing to:

The Company Secretary
Calderdale and Huddersfield NHS Foundation Trust
Acre Street
Lindley
Huddersfield
HD3 3EA

Membership of the committees and groups
The Council of Governors has established a Nomination and Remuneration Committee to consider the pay and succession arrangements for the non-executive directors.

Nominations and Remuneration of Non-Executive Directors
The Nominations and Remunerations Committee (Council of Governors) met on four occasions during 2017/18 and:

- Reviewed and agreed that their terms of reference should remain unchanged.
- Reviewed the Board skills and expertise.
- In line with the pay decisions for the Board Directors in 2017-18, the proposal for the Non- Executive Directors to maintain their current levels of basic remuneration and receive no uplift was agreed.
- Appointed Philip Lewer to succeed Andrew Haigh as Chair for Calderdale and Huddersfield NHS Foundation Trust for 3 year tenure with effect from 1 April 2018.

The Sub Committee for the Nominations and Remuneration Committee (Membership Council) during 2017/18 comprised of:-

ATTENDANCE				
NAME AND ROLE	**18.12.17**	**08.01.18**	**25.01.18**	**02.02.18**
Andrew Haigh, Chairman	√	√	√	√
Brian Moore, Publicly Elected Member/Deputy Chair	√	√	√	√
Stephen Baines	√	√	√	√
Lynn Moore	x	√	√	√
Katy Reiter	x	√	x	x
Di Wharmby	x	√	x	√

The Chair of the Board is also required to disclose any other significant commitments to the Council of Governors. The Chair did not have any other significant commitments to disclose during 2017/18.

Our Membership

Membership is free and aims to give local people and staff a greater influence over how our services are provided and developed. It also helps the Trust to work much more closely with local people and service users.

Our members have the chance to:

- Find out more about the hospitals, our community services, the way they are run and the challenges they face
- Help us work with local people to improve the care and experience of patients and their carers
- Elect representatives to the Council of Governors
- Public membership is open to people:
- aged 16 or over
- who are or have been a patient or carer at Calderdale and Huddersfield NHS Foundation Trust
- who live within our defined membership area

All eligible staff members automatically become Foundation Trust staff members unless they choose to opt out. Staff are eligible for membership provided that they fulfil one of the following criteria:

- they hold a permanent contract of employment with us
- they have been employed by the Trust on a temporary contract of 12 months or longer
- they are employed by the Trust or one of its partners (e.g. local government, other NHS Trusts) on a permanent basis or fixed-term contract of 12 months or more

Our membership as at 31 March 2018
Public members by constituency

Constituency	Members
1	529
2	1665
3	1021
4	447
5	1034
6	628
7	1204
8	1752
Total	8280

Our membership is broadly representative of the communities that we serve.

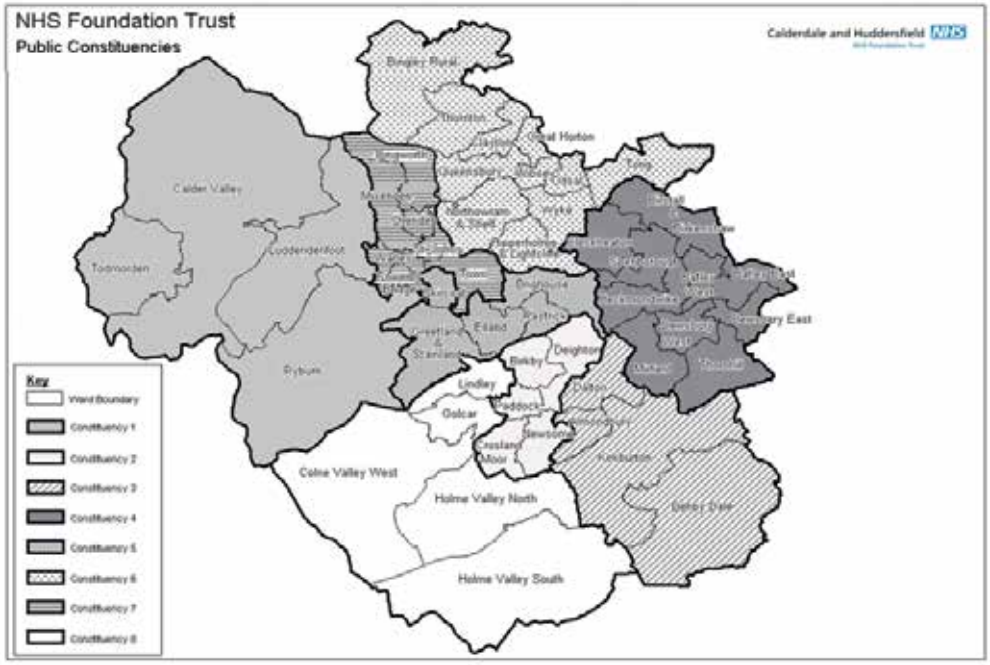
Staff members by constituency (staff group)	
Constituency (staff group)	**Members**
9 Doctors/dentists	528
10 AHPs/NCS/ Pharmacists	788
11 Management/Admin/ Clerical	1255
12 Ancillary	1777
13 Nurses/midwives	1853
Total	6201

Membership Strategy and Getting Involved
Our membership strategy is designed to help us reach out to the local communities that we serve, and to offer opportunities to become involved with the work of the Trust. Here are some examples:

- The views of members and governors are an important element in the recruitment process for senior Trust clinical staff. Governors and members have been part of the patient and user panels for the appointment of new consultants, senior nurses and senior non-clinical staff.
- Members and governors have taken part in the PLACE (Patient Led Assessment of the Care Environment) inspections on both hospital sites.
- Members and governors have taken part in patient food tasting exercises.
- Familiarisation tours to clinical and non-clinical areas are conducted by governors to help their understanding of the Trust's services for patients. Governors talk to both patients and staff to form a view about culture and performance. Areas covered this year include the Community Place; the recently reconfigured Respiratory and Cardiology services; the Pharmacy Department at HRI; the non-patient areas of our estate at HRI (boiler room etc.).
- Governors are involved in choosing quality indicators for our Quality Accounts. They discuss the indicators and are invited to give their views on these or to add their own suggestions. Members and governors then vote on the suggested improvement indicators, and progress against them is published in the Trust's Quality Accounts.
- Twice a year our newsletter, 'Foundation News', is published and distributed to all of the Trust's members. Through this, members get to learn about Trust services for patients, the work of their CoG and about forthcoming events.
- Members and governors have been involved in a "secret shopper" exercise in one of our clinical departments.
- Members and governors were invited to participate in the Trust's "discharge week" activities.
- A governor has been involved in the re-design of the public toilets at HRI, from a disability perspective.
- A governor performed a reading during the Christmas Carol Service at a local church.
- Members can pose questions directly to the chief executive or Trust chairman through a 'Members' Questions Inbox'. Similarly, members can contact the governors via the Trust's dedicated 'Contact Your Council Inbox'.

How to get in touch
If you would like to get in touch with a governor, 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 write to The Membership Office, Calderdale and Huddersfield NHS Foundation Trust, Freepost HF2076, Acre House, Acre Street, Lindley, Huddersfield HD3 3EA

The Council of Governors - Public Constituencies



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

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


Coffee
Coffee
Coffee

Regulatory report

All NHS foundation trusts require a licence from Monitor (now NHS Improvement) stipulating the specific conditions they must meet to operate, including financial sustainability and governance requirements.

In October 2017, NHS Improvement (NHSI) introduced the Single Oversight Framework (SOF) bringing together elements of the Monitor Risk Assessment Framework and the NHS Trust Development Authority Accountability Framework. It applies equally to all trusts.

The SOF aims to enable NHSI to identify the support needed by Trusts to deliver high quality, sustainable healthcare services and to help providers attain and maintain CQC ratings of 'good' or 'outstanding'. The SOF assesses providers' performance against five themes:

	Theme	Overview of oversight measures
1	Quality of Care	NHSI will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive in combination with in-year information where available Delivery of the four priority standards for 7-day hospital services
2	Finance and use of resources	Focus on a provider's financial efficiency and progress in meeting its control total Use of resources approach is being co-developed with CQC
3	Operational performance	NHS constitutional standards (18 week wait; cancer referrals) Other national standards (62 day cancer; A&E 4 hours; 6 week diagnostics)
4	Strategic change	How well providers are delivering the strategic changes set out in the Five Year Forward View with a particular focus on STPs, new care models and devolution (where relevant)
5	Leadership and improvement capability	Building on their well-led framework CQC and NHSI will develop a shared system view of what good governance and leadership looks like, including ability to learn and improve

Depending on the extent of support needs identified through its oversight process and performance against the above measures, NHSI segments providers into one of four categories. Segmentation is based on:

- All available information on providers – both obtained directly and from third parties
- Identifying providers with a potential support need in one or more of the above themes
- Using NHSI's judgement, based on relationship knowledge and/or findings of formal or informal investigations, or analysis, consideration of the scale of the issues faced by a provider and whether it is in breach or suspected breach of licence conditions (or equivalent for NHS trusts).

Of the five themes, providers are clearly assessed in two areas: finance and use of resources; and operational performance.

Finance and use of resources metrics

NHS Improvement oversees and supports providers in improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure.

Area	Weighting	Metric	Definition	Score			
				1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	<(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Providers score 1(best) to 4 against each metric and the score is averaged across all the metrics to derive a use of resources score.

The Trust's performance ratings against the Single Oversight Framework for 2017/18 were:

2017/18	Annual Plan	Q3	Q4
Financial risk rating/Use of Resources	3	3	3

The Trust continues to operate in a challenging financial environment being shaped by the national financial picture with the on-going need to reduce the public deficit and bring NHS finances at a national level back into balance. This sits alongside the continued pressures of investing in clinical staffing ratios, providing services 7 days a week and responding to increasing demand. In January 2015 Monitor (the regulator of foundation trusts at that time) declared the Trust to be in breach of licence as a result of an unplanned year-end deficit position of £4.3m which Monitor believed to be a breach of financial and board governance.

Monitor wrote to the Trust setting out the undertakings it expected the Trust to deliver:

- Delivery of the reforecast plan submitted in September 2014;
- Plan for 2015/16 and ensure the efficiency challenge is met and consistent with the national efficiency requirements detailed within the 'The Forward View into Action: Planning for 2015/16';
- Develop a strategic sustainability and financial turnaround plan for completion in September 2015.
- Completion of a Well Led Governance Review

NHS Improvement issued the Trust with a certificate of compliance for two of the three undertakings relating to board governance and effectiveness and general action.

The remaining undertaking requires the Trust to 'ensure the Licensee's clinical and financial stability is maintained from the end of the financial year 2016/2017'. While a business case setting out how clinical and financial stability could be achieved has been produced, the Trust remains in a deficit position and therefore NHS Improvement has not certified compliance with this final undertaking.

Operational performance metrics

The operational performance metrics are those that are used for our Sustainability and Transformation Funding. NHS Improvement will consider whether there is a potential support need if a provider fails to meet any trajectory for at least two consecutive months.

Standard	Frequency	Standard
A&E maximum waiting time of 4 hours from arrival to admission/transfer/discharge	Monthly	95%
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway	Monthly	92%
All cancers – maximum 62-day wait for first treatment from: - urgent GP referral for suspected cancer - NHS cancer screening service referral	Monthly	 85% 90%
Maximum 6-week wait for diagnostic procedures	Monthly	99%

The operational performance metrics are monitored monthly by the Board through the Integrated Performance Report. More information on the Trust's performance against these standards and further disclosures in relation to income and the Going Concern statement can be found in the Performance Report on p18.

Voluntary Disclosures

Equality & Diversity

The Trust strives to provide the highest quality of service to all of its patients. Equality and diversity considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care.

The Trust also has a legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between people who identify with a protected characteristic. These characteristics are: age, disability, gender reassignment, marriage or civil partnership, pregnancy or maternity, race, religion or belief, sex, and sexual orientation.

The outcomes of the NHS' Equality Delivery System 2 (EDS2) help us to focus our work around equality and diversity, and to decide on our equality objectives.

We identified our priority outcomes for 2016 to 2020 as:

- Individual people's health needs are assessed and met in appropriate and effective ways.
- People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds.
- When at work, staff are free from abuse, harassment, bullying and violence from any source.
- Papers that come before the Board and other major committees identify equality-related impacts including risks, and say how these risks are to be managed.

Some examples of what we have done in 2017/18 to achieve these outcomes are shown below:

Protected Group	What we have done	EDS2 Outcome
All	At the start of 2017 we launched an electronic equality impact assessment process. The process includes a mechanism to ensure that assessments are completed before proposals to introduce new policies or service changes are submitted to the Board or other major committees. During 2017, there were 113 completed assessments.	4.2
	During 2017 the Trust has started the procurement process for a new patient correspondence system and has included a section within the tender documentation which asks how the successful bidder will ensure full compliance with the Accessible Information Standard.	2.1
Age (older people)	In 2017 the Trust purchased dementia friendly crockery for wards that typically care for dementia patients on the Huddersfield site. The crockery has been tested by the Food for Life partnership and is considered to be the best product available for this group of patients. Patient and carer feedback on the crockery to date has been very positive. Our PFI partners are also hoping to introduce the crockery on the Calderdale site.	1.2
	The Trust has purchased a RemPod - unique pop-up reminiscent scenes provided with authentic furniture, replica TVs, record players, or cinema screens, and nostalgic accessories and games. They transform clinical environments into therapeutic and reminiscent spaces, helping to change the quality of life for people living with dementia. This is being trialled for working with our dementia patients. 	1.2

Protected Group	What we have done	EDS2 Outcome
Disability (visual impairment)	Feedback from patients/carers has shown that the introduction of dementia friendly crockery at HRI has also had a positive impact for patients with a visual impairment due to its colour.	1.2
Age (younger people)	We have opened a dedicated room for young people to socialise and relax (the Teenage Room) on our Children's Ward. 	1.2
	When attending Ophthalmology outpatient appointments, children are seen within an adult setting. We have introduced a new child friendly waiting area to ensure that the needs of our younger patients can be met appropriately.	1.2
Disability (physical)	The plans to upgrade the public toilets in the main entrance at the HRI site during 2017/18 include an upgrade of the accessible toilets.	2.1
	The appropriateness of the environment for patients with a physical disability is assessed as part of the annual PLACE (patient led assessment of the care environment) inspections. In 2017 HRI scored 89.4% and CRH scored 88.9%. These scores were broadly in line with the national average.	2.1
Race	It is known that patient outcomes and the patient experience is improved when those staff providing care who have a protected characteristic feel valued and respected by the organisation. To address this, since 2016 the Trust's Chief Executive has led on a programme of focus groups for BME colleagues.  This has resulted in a strategy and action plan and the group has continued to meet on a quarterly basis throughout 2017 to progress this work.	3.4
Sexual Orientation	In November 2017 the Trust hosted a regional event to raise awareness of the experiences of LGBT patients receiving care in the NHS and the experiences of LGBT staff working for the NHS:  The event was well received and we are planning to host a similar engagement event in the community in 2018.	1.2, 2.1 & 3.4

Protected Group	What we have done	EDS2 Outcome
Sexual orientation	During 2017 managers within the Radiology Department have been working on a process to address the sensitivity around the requirement, when undertaking examinations that involve ionising radiation, to ask transgender patients about the possibility of them being pregnant. This work will be ongoing in 2018, in conjunction with a local expert.	1.2
Religion/ belief	Together with colleagues from Overgate Hospice and Calderdale Council, Trust staff have been shortlisted for an Accolade Award for their work with Calderdale Council of Mosques centred on the South Asian community in West Halifax. A partnership has been formed with the Horizon Group, to establish a programme of education, explaining concepts of palliation and strategies of care to the South Asian community:  This also gives Trust colleagues the opportunity to hear of possible ethical, cultural and religious misgivings that members of the community may have.	1.2 & 2.1
Pregnancy/ Maternity	Privacy and dignity concerns raised by our patients highlighted a need to work closely with our junior doctors prior to them working in maternity services at CHFT. A session has therefore been incorporated into the junior doctors' induction course, the focus of which is 'walking in the woman's shoes'. This involves scripting and role playing women's stories and specific areas covered include informed consent, privacy and dignity.	1.2
Disability (learning) & Pregnancy/ Maternity	The Lead Matron for Learning disabilities at CHFT has agreed to create a bespoke training session for maternity staff about caring for pregnant ladies with a learning disability and plans to invite a previous user of the service to contribute to the session	1.2

As part of its collaborative approach to the EDS2, early in 2017 staff from CHFT attended two grading panels (made up of members of third sector organisations) in Kirklees and Calderdale. They presented the progress the Trust had made on two initiatives linked to its four priority goals.

Both initiatives were graded as 'developing' and the feedback from the panels was that the Trust should focus on having more inclusive engagement activities, using different approaches for different groups rather than having a "one size fits all" approach.

There is awareness across the Trust of the importance of listening to, and responding to, patient feedback. This is championed through the representatives on the Trust's Patient Experience and Caring Group. More innovative approaches are being introduced to gather feedback and create opportunities to listen, through a range of feedback options that sit alongside the more formal methods of feeding back such as through the Friends and Family test, complaints, PALs and surveys.

The Friends and Family test has been implemented across the Trust in line with national guidance; this is the main opportunity for service users to provide their feedback. A range of methods is used to engage patients with this initiative: postcards, text messaging and web-based solutions. Easy read cards are also available for patients with a learning disability.

The Trust is working with the Yorkshire & Humber Improvement Academy to conduct face to face interviews with patients. These surveys, known as PRASE (Patient Reporting and Action for a Safe Environment) are conducted by trained volunteers at ward level, and following completion of a minimum of 20 surveys a report is generated and shared with representatives from the ward team. To date surveys have been undertaken on the surgical wards, and are now being rolled out to other areas - initially the medical and paediatric wards.

Wards and departments use a variety of other methods to encourage patient feedback, including direct contact through rounding by the ward managers and Matrons, debriefs, guest books and graffiti boards.

During 2017, colleagues in maternity services worked with HealthWatch to better understand how to engage with service users about their experiences. This enabled a critical review of ways in which staff listened to users and learned from experience – with previous methods tending to be linear and quantitative data based, rather than personalised.

The service is now focussing on experienced based co-design to capture intelligence regarding some of the work streams from 'Better Births', which in the first instance will highlight the experience of women with complex needs.

Slavery and Human Trafficking Act 2015
The Board of Directors approved a statement at its meeting in May 2018 confirming compliance with the requirements of the Slavery and Human Trafficking Act 2015. The required statement has been published on the Trust's website and can be found at www.cht.nhs.uk/publications.

Counter-fraud policies and procedure
The Trust's counter-fraud arrangements are compliant with the NHS Standards for providers: fraud, bribery and corruption. These arrangements are underpinned by the appointment of accredited local counter fraud specialists and the introduction of a Trust-wide countering fraud and corruption policy. An annual counter fraud plan identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud is produced and approved by the Trust's Audit and Risk Committee.

The NHS Constitution
All NHS bodies are required by law to comply with the NHS Constitution, the national document which details the principles and values of the NHS in England. The Constitution sets out rights to which patients, the public and staff are entitled and pledges that the NHS is committed to achieve. It also describes the responsibilities that patients, staff and the public owe to one another to ensure the NHS operates fairly and effectively. Our Trust is fully compliant with the requirements of the NHS Constitution.

Owen Williams
Chief Executive
23 May 2018

Statement of the chief executive's responsibilities as the accounting officer of Calderdale and Huddersfield NHS Foundation Trust

The National Health Service Act 2006 (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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Calderdale and Huddersfield NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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, items of other comprehensive income and cash flows for the financial year.

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

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and use the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

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 them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error and 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. The accounting officer is also responsible for ensuring that the use of public funds complies with the relevant legislation, delegated authorities and guidance.

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

Signed

Owen Williams
Chief Executive
Date: 23 May 2018

Annual Governance Statement 2016/17

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.

There are arrangements in place for sharing views and working with other organisations. Those operating at Chief Executive level are as follows:
- West Yorkshire Association of Acute Trusts
- West Yorkshire and Harrogate Health and Care Partnership
- NHS Calderdale Clinical Commissioning Group
- NHS Greater Huddersfield Clinical Commissioning Group
- Health Overview and Scrutiny Committees (Calderdale, Kirklees)
- Health and Wellbeing Boards (Calderdale, Kirklees)
- Healthwatch (Calderdale, Kirklees)
- Yorkshire and Humber Learning Education and Training Board

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 strategic aims and objectives of Calderdale and Huddersfield NHS Foundation Trust;
- 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 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
The Trust's vision is 'Together we will deliver outstanding compassionate care to the communities we serve'. This is supported by the Trust's values, the four pillars of behaviour that it expects all employees to follow. These are:
- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The Trust's governance arrangements support these The Trust's governance arrangements support these behaviours.

The Board of Directors provides leadership on the overall governance agenda including risk management. It is supported by a number of sub-committees that scrutinise and review assurances on internal control. These include:
- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- Workforce Committee

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit & Risk Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Quality Committee. The Board of Directors routinely receives the minutes of these Committees alongside the Board Assurance Framework and the high level risk register.

The Risk and Compliance Group oversees all risk management activity to ensure:
- that the correct strategy is adopted for managing risk;
- controls are present and effective;
- action plans are robust for those risks that are being actively managed; and
- that high risks are scored appropriately.

The Risk and Compliance Group is chaired by the Executive Director of Nursing and comprises senior management representation from all divisions. Other senior managers and specialist leads routinely attend each meeting. While the Risk and Compliance Group reports directly to the Audit and Risk

Committee, it also provides a monthly report on the high level risks and mitigating actions to the Board and Quality Committee for review of clinical risks works with other committees of the Board in order to triangulate material issues in accordance with the Board's appetite for taking risk and ensure a coordinated approach to effective risk management. The Chief Executive has overall responsibility for the management of risk. Other members of the Director Team exercise lead responsibility for the specific types of risk as follows:

The Chief Executive has overall responsibility for the management of risk. Other members of the Director Team exercise lead responsibility for the specific types of risk as follows:

Strategic risk	Chief Executive
Clinical and quality risks	Executive Director of Nursing / Medical Director
Financial risk	Executive Director of Finance
Workforce risk	Executive Director of Workforce and Organisational Development
Staffing risk	Chief Nurse / Executive Medical Director
Environmental risk	Executive Director of Planning, Estates and Facilities
Operational risk	Chief Operating Officer
IT risk	Managing Director – Digital Health

All board level directors are responsible for ensuring there are appropriate arrangements and systems in place in order to:

- Identify and assess risks and hazards
- Comply with internal policies and procedures, and statutory and external requirements
- Integrate functional risk management systems and develop the assurance framework.

These responsibilities are supported operationally by divisional directors and managers.

The Trust has recently reviewed its Risk Management Strategy which describes the Trust's vision for risk management. The Risk Management Strategy is aligned to the Trust's values, details the lines of defence that the Trust has in place to manage and mitigate risk, the tools used to manage risk and clearly describes the process for managing risk and the roles and responsibilities of staff. The Risk Management Policy, which supports the Risk Management Strategy, provides details of risk management systems and processes at an operational level, including the risk register. The Trust also has a Maternity Risk Management Strategy which sets out responsibilities for the risk management of maternity services within the organisation in line with good practice.

The purpose of the Risk Management Strategy is to confirm the objectives and organisational framework for risk management systems within the Trust. It details roles, responsibilities and processes for risk management in order to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The Policy sets out a clear, systematic approach to risk management that ensures it is an integral part of the clinical, managerial, quality and financial processes within the organisation. Risks are identified, managed and reviewed at a department, directorate and divisional level as appropriate.

During 2016/17 the Board considered and set its risk appetite. An organisation's risk appetite is defined as the amount and type of risk that the organisation is willing to take in the pursuit of its strategic objectives. The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved and communicating expectations for risk taking to managers. The risk appetite is due to be reviewed at a Board workshop in May 2018.

Risk Category	This means	Risk Appetite level	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial / Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**
Commerical	We are willing to take risk in relation to new commercial opportunities where the potential benefits outweigh the risks. New opportunities are seen as a chance to support the core business and enhance reputation.	**SEEK**	**SIGNIFICANT**
Harm and safety	We will take minimal risk, or as little as reasonably possible, when it comes to patient safety and harm and clinical outcomes. We consider the safety of patients to be paramount and core to our ability to operate and carry out the day-to day activities of the organisation.	**MINIMAL**	**LOW**
Workforce	We will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual's competence to perform roles or task safely and, or any circumstances which may compromise the safety of any staff member or group. We are eager to be innovative in considering risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.	**SEEK**	**SIGNIFICANT**
Quality innovation and improvement	In order to achieve improvements in quality, patient safety and patient experience we will pursue innovations for our services. We are willing to consider risk options associated with development of new models of care, clinical pathways and improvements in clinical practice.	**OPEN**	**HIGH**

The Board has set out the minimum requirements for staff training required to control key risks through a clear mandatory training programme including infection control, fire safety, safeguarding adults and children, information governance and manual handling. During 2017/18 we achieved 94.9% compliance against this programme. We also have a health & safety training programme from Board to ward. The mandatory training framework describes the requirements for each staff group and the frequency of training in each case.

In addition there is training in incident investigation, including documentation, root cause analysis, serious incidents and steps to prevent or minimise recurrence and reporting requirements.

Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons learned and to help improve internal control and are reported to the Board through the quarterly Quality Report.

I have ensured that all risks of which I have become aware are reported to the Board of Directors and to the Risk and Compliance Group. All new significant risks are escalated to me as Chief Executive and the executive team. They are reviewed and validated by the Risk and Compliance Group. The risk score determines the escalation of risks. There is a regular programme of review of risks on the Board Assurance Framework which enables the Board of Directors to scan the horizon for emergent threats and opportunities and consider the nature and timing of the response required in order to ensure risk is kept under appropriate control at all times.

The risk and control framework

The system of internal control is based on an on-going risk management process that is embedded in the organisation and combines the following elements:

- Setting the risk management objectives
- Setting the risk appetite
- Risk Management Strategy
- Risk Management Strategy for Maternity
- Risk Management Policy and reporting
- Risk Register and Board Assurance Framework
- Incident reporting, claims and complaints
- Trust's Strategic Plan
- Financial governance
- Quality governance
- Information governance

Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks which may adversely affect patients, staff, contractors, the public and the fabric of buildings, are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach thereby providing a safe environment in which patients can be cared for, staff can work and the public can visit.
- Risks are managed to an acceptable level as defined in the Board's Trust risk appetite and staff have a clear understanding of exposure and the action being taken to manage significant risks.
- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated.
- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively.
- All staff recognise their personal contribution to risk management
- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

Risk Management Policy and reporting

The Trust's risk management arrangements ensure that action is taken 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. Risk management requires active participation and commitment from all staff. It is an intrinsic part of the way the business of the Trust is conducted and its effectiveness is monitored by the Trust's performance management and assurance systems.

The risk management process is set out in six key steps as follows:

i. Determine priorities

The Board of Directors determines corporate objectives annually and expresses these in specific, measurable, achievable ways with clear timescales for delivery. This then establishes the priorities for executive directors and services. Risk is defined as anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful in achievement of these objectives.

ii. Risk Identification
Evaluating what is stopping, or anticipating what could prevent the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats. The Board of Directors, senior leaders and divisional teams will identify what is uncertain, consider how it may be caused and what impact it may have on the objective and service.

iii. Risk Assessment
Risk assessment involves the analysis of individual risks, including analysis of potential risk aggregation where relevant. The assessment evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

iv. Risk Response
There are a number of different options for responding to a risk. These options are referred to as risk treatment strategies. For each risk, controls are ascertained (or where necessary developed), documented and understood. Controls are implemented to:

- seek risk (take opportunity);
- accept risk (where no further mitigating action is planned and the risk exposure is considered tolerable and acceptable);
- avoid risk (withdrawal from the activity that gives rise to the risk);
- transfer risk (either in part or in full to a third party which may be achieved through insurance, contracting, service agreements or co-production models of care delivery);
- or modify risk (put in place specific controls designed to change either the severity, likelihood or both)

Gaps in control are subject to action plans which are implemented to reduce residual risk.

v. Risk Reporting
All risks are recorded on the risk register. Significant risks (scoring 15 or above) are reported at each formal meeting of the Board of Directors. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and executive team. The level at which risk must be escalated is clearly set out in the Risk Management Strategy. The risk report to the Board of Directors also details what action is being taken, and by whom, to mitigate the risk and monitor delivery. The Audit and Risk Committee have reviewed assurance on the effective operation of controls to manage potential significant risk. The Board of Directors has in place an up-to-date Board Assurance Framework which set outs the potential risks to the Trust's strategic objectives.

vi. Risk Review
Risks are reviewed at a frequency proportional to the residual risk which is detailed in the Risk Management Policy. Discretion regarding the frequency of review is permitted. As a minimum risks scoring over 15 are reviewed monthly. Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. Risk profiles for all Divisions are subject to detailed scrutiny as part of a rolling programme by the Risk and Compliance Group. The purpose of the Trust's risk review is to track how the risk profile is changing over time; evaluate the progress of actions to treat material risk; ensure controls are aligned to the risk; resources are reprioritised where necessary; and risk is escalated appropriately.

<u>The High Level Risk Register and Board Assurance Framework</u>
Operational risk registers are maintained in wards and departments, and for time limited projects. Divisional registers consolidate directorate risks scoring 8 or above and any additional business risks to the division. Divisional registers are discussed in detail at the Divisional Patient Safety and Quality Board and reviewed on a bi-monthly basis by the Risk and Compliance Group. The highest rated risks are taken to Risk and Compliance Group for review and consideration of action plans and the implementation of any plans. These risks are considered for escalation to the high level risk register.

Each board level director is responsible for their section of the Board Assurance Framework. The statements given in the framework are provided by the director who is accountable for the area. Directors are asked to consider and confirm the detail included in the framework. The Board

Assurance Framework is linked to the high level risk register through a consideration of the risks on the risk register and the assurance statement included in the Board Assurance Framework.

The Risk and Compliance Group receives both the Board Assurance Framework and high level risk register and considers the detail included.

The Audit and Risk Committee receives the Board Assurance Framework on a quarterly basis in order to satisfy itself that the processes for populating, updating and the format of the document remain relevant and effective for the organisation.

In October 2017, the Audit and Risk Committee received a report on the work undertaken to strengthen risk management processes within the Trust from ward to Board from August 2016 to September 2017. The review ensured that the Trust's risks were aligned to the Trust's 5 year strategy and one year plan and risks to all Trust objectives were captured.

The review clarified the difference between the Board Assurance Framework and the high level risk register and the relationship between the two. This led to proposals to remove areas of duplication and identify new risks relating to the following areas that were not currently captured on either the Board Assurance Framework or the high level risk register. The following additional areas of risk were proposed and included as appropriate:

- Board Assurance Framework (BAF) – strategic partnership work, patient and public involvement
- High level risk register – leadership, health and safety action plan, development of workforce and bank models.

Risks on the BAF and high level risk register are now all cross referenced to each other, with a summary of the BAF risks included with the high level risk register and vice versa and inclusion on both of the risk appetite.
The high level risk register continues to be reported to Board each month setting out the risks scoring 15 or above. The BAF is reviewed at each of the Board sub-committees every three months prior to being reported to the Board.

During 2017/18 an internal audit report on the Board Assurance Framework gave an opinion of significant assurance with only one recommendation for improvement.

Incident Reporting
Incident reporting and investigation is recognised as a vital component of risk and safety management and is key to being a learning organisation. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. There is an escalation process for incidents and the executive team are alerted when a new incident is reported.

- Adverse incident reporting - The Trust promotes a culture of openness and transparency and staff are advised on the Trust's approach to this through the Being Open / Duty of Candour Policy. The key reporting systems the Trust uses are included in the Datix system. Use of the system provides an opportunity for the Trust to learn from incidents, together with complaints and claims and improve services.
- Serious incident reporting - The Trust has during the year continued to embed the Serious Incident investigation process and share learning from investigations with staff. This has included the use of Director Review panels to assess the most serious incidents. Divisional panels are also held to assess moderate harm incidents and agree the most appropriate level of investigation. A Serious Incident Review Group, chaired by the Chief Executive and with senior clinical divisional representation, also reviews serious incidents and aims to ensure that cross divisional learning from serious incidents is taking place. The group also reviews national reports on learning from incidents and reviewed the Trust's response to the Care Quality Commission report, Learning, Candour and Accountability.

The Clinical Commissioning Groups require the completion of all investigations and for them to be provided to the Clinical Commissioning Groups with approved reports within 60 days of being raised. The Trust has systems in place to meet this requirement.

- Never events - The Trust experienced one never event during 2017/18 (two in 2016/17 and two in 2015/16). When there is a never event it is investigated in detail and the Trust aims to learn from the event. The results of these investigations are reported to the Quality Committee and the Board of Directors.

- Claims – The Trust has robust processes in place for dealing with both Clinical Negligence and Employers Liability Claims. When necessary we seek legal representation. A summary of any settled claim is disseminated where appropriate to:
  - involved clinician(s)
  - Relevant Clinical Director / Divisional Director
  - Directors
  - Health and Safety Team where appropriate

Quarterly reports on claims are presented to the Risk and Compliance Group.

The Parliamentary Health Service Ombudsman's report, Learning from Mistakes, July 2016, reiterated that training and accrediting sufficient investigators is crucial to improve learning from investigations. During 2017/18 we have run a training programme to support staff in their investigative approach to patient complaints. This training incorporates the process of how to ensure good quality investigations are undertaken and that the tools for capturing and disseminating learning are known.

Learning from complaints is closely linked to learning from incidents that have caused severe or moderate harm. Having a culture where the expectation is to learn, no matter what happened is key, as well as involving patients and families. Work was undertaken with staff to identify how we can best share learning across the Trust resulting in variety of communication methods including intranet site; bite-size learning; learning newsletters; screensavers and quality improvement social media accounts.

In respect of learning lessons from claims, Directorates are provided with details of new, on-going and settled claims. Directorates ensure that risk issues are identified and formally discussed in order for an action plan to be initiated and where necessary the relevant risk register be appropriately updated. These action plans are monitored through the Directorate risk process.

In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary. The Trust has a named Freedom to Speak Up Guardian and has recently revised the Raising Concerns policy to reflect national guidance.

Trust Strategic Plan

In May 2017, the Board of Directors agreed the annual plan – setting out its key areas of delivery for year three of the five year plan. The plan aims to achieve the Trust vision of 'Together we will deliver outstanding compassionate care to the communities we serve' and is built around the four goals of the Trust:

- Transforming and improving patient care
- Keeping the base safe
- A workforce fit for the future
- Financial sustainability

The risks to the achievement of the goals are described in the Board Assurance Framework as:

Transforming and improving patient care

- Risk that the Trust will not secure agreement to implement the proposals set out in its Full Business Case for the reconfiguration of hospital services resulting in poor quality of care and impacting on workforce resilience.
- Risk of non-delivery of the West Yorkshire Association of Acute Trust's programme as part of the wider West Yorkshire Sustainability and Transformation Partnership due to internal focus, lack of partnership working and capacity resulting in enforcement action and inability to achieve a rating of 'advanced'.
- Risk that the Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.
- Risk that the Trust does not involve and engage patients and the public in the delivery and improvement of services due to lack of clear processes, capacity and capability resulting in poor patient experience, poor quality of care and challenge to service change decisions.
- Risk that the Trust will not realise the safety, quality and financial benefits from the implementation of the Trust's Electronic Patient Record due to lack of optimisation of the system.

Keeping the base safe

- Risk that patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.
- Risk that the Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement resulting in enforcement action.
- Risk of failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.
- Risk of failure to maintain current estate and equipment and to develop a future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.

A workforce fit for the future

- Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
- Risk of not having colleagues who are confident and competent to provide clinical and managerial leadership due to a lack of clear strategy and focus on development for current and aspiring leaders resulting in an inability to deliver the Trust's objectives and sustainable services for the future.
- Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the culture of the organisation due to a lack of robust engagement mechanisms.

Financial sustainability

- Risk that the Trust will not deliver the long term financial plan due to reduced income, inability to deliver the cost improvement plan and additional pressures, resulting in regulatory intervention.
- Risk that the Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.

As at 31 March 2018 Calderdale and Huddersfield NHS Foundation Trust had identified a number of risks, which are being managed and mitigated, scoring 15 or above on the high level risk register which could impact on the achievement of corporate objectives, compliance with its licence or Care Quality Commission in the following areas:

- Intensive Care Unit / Estates joint risk
- 2018/19 Capital Programme
- Medical staffing risk
- Patient flow
- Over-reliance on locum middle grade doctors in A&E
- Urgent estates schemes not undertaken
- Nurse staffing risk

The risk register sets out the arrangements for risk treatment, risk appetite thresholds and further mitigating actions planned.

In addition, each month the Board reviews the Integrated Performance Report (IPR), following detailed scrutiny at the appropriate Board sub-committee and by the executive management team. The IPR sets out the operational, quality, workforce and financial performance targets and indicators. Each is assigned an executive lead who is accountable for the achievement of the target and ensuring appropriate monitoring, management and mitigation of any risks to achievement of the target is in place.

<u>Quality and financial governance</u>

The Trust continues to operate in a challenging financial environment being shaped by the national financial picture with the on-going need to reduce the public deficit and bring NHS finances at a national level back into balance. This sits alongside the continued pressures of investing in clinical staffing ratios, providing services 7 days a week and responding to increasing demand. The Trust also continues to be under enforcement action from its regulator NHS Improvement following the breach of licence in 2014/15. The breach of licence resulted in actions for the Trust to complete:

- Delivery of the reforecast plan submitted in September 2014;
- Plan for 2015/16 and ensure the efficiency challenge is met and consistent with the national efficiency requirements detailed within the 'The Forward View into Action: Planning for 2015/16';
- Develop a strategic sustainability and financial turnaround plan for completion in September 2015.
- Completion of a Well Led Governance Review

NHS Improvement issued the Trust with a certificate of compliance for two of the three undertakings relating to board governance and effectiveness and general action.

The remaining undertaking requires the Trust to 'ensure the Licensee's clinical and financial stability is maintained from the end of the financial year 2016/2017'. While a business case setting out how clinical and financial stability could be achieved has been produced, the Trust remains in a deficit position and therefore NHS Improvement has not certified compliance with this final undertaking.

The Trust is also rated as level 3 under the Single Oversight Framework and has quarterly performance review meetings with NHS Improvement.

The Trust's full business case included a detailed review of the clinical, operational and financial challenges facing the Trust.

Clinical challenges;

- The provision of dual site services is impacting on the quality of care provided to patients.
- Current configuration of services is not in line with National Clinical Advisory Team's recommendation or the Clinical Consensus Model agreed between the Trust's clinicians and GP commissioners.
- Emergency departments do not meet Royal College recommendations / standards.
- The Trust suffers from a larger than average Hospital Standardised Mortality Ratio (HSMR).

Operational challenges;

- The Trust is not able to recruit for or retain an adequate workforce of substantive staff to meet demand. In particular, there are difficulties in recruiting middle grade doctors in A&E and consultants in a number of key medical specialties.
- Provision of dual services is impacting operational performance in terms of patient pathways and workforce cover.

Financial challenges;

- The Trust is reporting an underlying deficit of £61.1m for FY19.
- Provision of dual services across two sites is expensive, resulting from duplication of costs and the additional difficulties this presents in relation to recruiting and retaining staff.
- Both estates are expensive to run in terms of upgrade requirements and PFI contracts.

These risks are included on the Board Assurance Framework and the corporate risk register where appropriate.

The Trust has a detailed cost improvement programme managed through a programme management office arrangement which reports to the Turnaround Executive Group. Financial risks are identified and escalated for detailed scrutiny by the Finance and Performance Committee. All of the programmes are required to complete a Quality Impact Assessment. Any risks identified through this process are reported and mitigation plans put in place. These are reported to the Quality Committee.

At 31 March 2018 the Trust reported a year end deficit of £29.9m and a use of resources risk rating of 3. The Trust also delivered a cost improvement programme of £17.9m against the planned level of £20m.

Information governance

Robust information governance is extremely important to us. The Trust uses the Connecting for Health information governance toolkit framework to assist in the identification of risks and weakness in relation to its information assets, including the systems and media used in processing and storing of information. The existing framework is used for the process of identification, analysis, treatment and evaluation of potential and actual information governance risks, with risks being recorded on the relevant Divisional or Corporate Risk Register.

The Trust's Senior Information Risk Owner (SIRO) supported by information asset owners, is responsible for the information risk programme within the Trust, and works closely with the Caldicott Guardian. Information governance risks are managed in accordance with compliance with the standards contained within the Information Governance Toolkit, and, where appropriate, recorded on the high level risk register. Detailed scrutiny of Information Governance risks is undertaken through the Information Governance Group. The Risk and Compliance Group and the Quality Committee will receive ad-hoc reports when a significant issue is identified.

The Caldicott Guardian is responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. The Guardian plays a key role in ensuring that the NHS, Councils with Social Services responsibilities and partner organisations satisfy the highest practicable standards for handling patient identifiable information.

The Chief Executive has overall responsibility for all aspects of information management, including security and governance, and is accountable to the Board of Directors.

The Trust takes data security and management very seriously. The Trust has well established systems to ensure data security and management is maintained at all times. The Trust has implemented a number of measures to mitigate the risk of loss and disclosure of personal identifiable information including a programme of encryption which has ensured that all existing and new supported laptop devices should be encrypted. Additionally, removable media used to transfer confidential information must be encrypted, in line with the Trust's Data Encryption and Protection Policy. A number of policies and supporting staff guidance materials set the parameters and expectations around the safe and secure handling and transfer of confidential information.

Confidentiality and information security awareness training is provided to all staff in the Trust's Induction Programme and through mandatory annual Information Governance training which is monitored by the Board through the Integrated Board Report. Training is also targeted at specific areas or staff groups on a risk basis. 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 organisation has a well-tested disaster recovery plan for data which aims to ensure that data, and access to data is not compromised or vulnerable at a time of any unexpected system downtime. Detailed reviews are undertaken following any incidence of systems failure and learning shared across systems.
All staff are governed by the NHS Confidentiality Code of Practice, and access to data held on IT systems is restricted to authorised users. Information governance training is incorporated into the statutory/mandatory training programme and supplemented as appropriate in all IT training sessions.

There have been two Information Commissioner's Officer (ICO) reportable incidents in the last 12 months both reported in October. The first related to information disclosed in error. A complaint meeting was held in the hospital to discuss a complaint unrelated to the patient. At the start of the meeting all parties consented to the meeting being recorded and were aware of the purpose of the meeting. During the meeting information was disclosed about the patient that was not to be shared. Unfortunately, when processing this complaint, staff did not make the complaints department aware of confidential information on the recording and the audio recording was sent to complainant as per normal process.

The second related to inappropriate access to personal data.

Both incidents have subsequently been closed by the ICO and Trust and mitigation/lessons learned are in place. In particular the Trust has sent reminder information to staff about the appropriate use of IT systems. This has been particularly important given the increased use of IT in relation to the implementation of the new Electronic Patient Record System.

Organisations are required to undertake a self-assessment against NHS Digital's Information Governance Toolkit and can score from 0-3 against each requirement. The Trust complies and has attained level 2 or greater, with all the requirements of the Information Governance Toolkit.

Care Quality Commission

Compliance with the Trust's Care Quality Commission registration is co-ordinated by the Executive Director of Nursing, who oversees compliance by:

- reporting and keeping under review matters highlighted within inspections;
- liaising with the Care Quality Commission Compliance Inspectors and divisional senior clinicians and managers in response to any specific concerns that are raised with the Care Quality Commission by patients and members of the public;
- engaging with the Care Quality Commission Compliance Inspectors on the inspection process and co-ordinating the Trust's response to inspections and any recommendations or actions that arise;

- analysing trends from incident reporting, complaints, and patient and staff surveys and sharing the learning from these across the Trust;
- reviewing assurances on the effective operation of controls;
- receiving details of assurances provided by Internal Audit and any clinical audit conclusions which provide only limited assurance on the operation of controls; and
- challenging assurances or gaps in assurance through chairing the Risk and Compliance Group

Calderdale and Huddersfield NHS Foundation Trust is required to register with the Care Quality Commission and has full registration without conditions.

During March and April 2018 the Trust received its first full Well Led Care Quality Commission inspection and was also one of the first trusts in Yorkshire and the Humber to receive a Use of Resources inspection by NHS Improvement. The report is expected in early summer. There were no immediate actions or improvement notices issued following the inspection.

Action taken following the previous inspection included:

- A strengthening of governance processes at Divisional and ward level with increased support from the corporate Risk and Governance Team and more robust quality and assurance arrangements at ward and department level. (Effective)
- Development of methods for sharing learning from adverse events. (Well Led)
- The Trust's approach to improved staffing has been strengthened with a number of initiatives introduced to increase staffing in both the nursing and medical workforce. (Well Led, Safe, Effective)
- Maternity services have strengthened their approach to receiving and responding to feedback from women and greater engagement with service users is seen as key to the success of this. (Safe, Caring, Effective)

These areas received positive comments from inspectors during the recent inspection.

Compliance with the NHS foundation trust condition 4

As one of the conditions of its breach of licence, the Trust was required to undertake an independently assessed Well Led Governance Review.

A prioritised action plan was developed for delivery over a 12 month period and was monitored through the Trust's monthly performance review meetings with NHS Improvement. The actions included:

- Development of a risk management culture and processes;
- Implementation of a performance management framework;
- Development of data quality kite mark;
- Sharing of lessons learned.

The action plan was fully delivered and signed off by the Board in November 2016.

These actions and the assurance processes described in this statement allow the Board to issue an accurate Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b) of NHS Improvement's provider licence. The Trust will use the learning from its recent Care Quality Commission Well Led and NHS Improvement Use of Resources inspections to form the basis of a self-assessment against the NHS Improvement well led framework during 2018/19.

The Trust has applied the principles, systems and standards of good corporate governance and has reviewed the guidance that has been issued by NHS Improvement during the year and where appropriate has prepared a 'comply or explain' document to record where the Trust has not followed the guidance or where an action plan is required to ensure compliance.

Communication with stakeholders

The Trust's communications team works closely with the quality team and the membership office. Together they ensure there is public stakeholder engagement that addresses any perceived or actual risks that might impact on the public. This includes undertaking any necessary consultation exercises.

A number of forums exist that allow communication with stakeholders, the forums provide a mechanism for risk identified by stakeholders that affects the Trust to be discussed and where appropriate action plans can be developed to resolve any issues.


NHS

Compliance with NHS pension scheme regulations
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into 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.

Compliance with equality, diversity and human rights legislation
Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust takes due regard of equality and human rights issues during the development of any service or change to service and the Management of Policies, this includes a detailed requirement to undertake equality analysis as part of the formulation of any new or updated policy.

The Trust complies with the requirements included in the Modern Slavery and Human Trafficking Act 2015.

Climate change and adaptation reporting requirements under the Climate Change Act 2008
Calderdale and Huddersfield NHS 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.
A Sustainable Development Group including Executive and Non-Executive Directors overseas the Sustainable Development Action Plan that is used to target specific areas within the broader sustainability agenda such as recycling and more sustainable travel.

Review of economy, efficiency and effectiveness of the use of resources
As Accounting Officer I am responsible for ensuring that the organisation has arrangements in place for securing value for money in the use of its resources. To do this I have:

- Put in place systems to set, review and implement strategic and operational objectives;
- Established a programme management office to oversee the development and implementation of robust cost improvement plans;
- Monitor and improve organisational performance; and
- Developed engagement processes with patients, staff, members and other stakeholders to ensure key messages about services are received and acted upon.

The Trust produces an annual operational plan and supporting detailed financial plan which is approved by the Board and submitted to NHS Improvement. This includes an assessment of the resources required to deliver the commissioned level of clinical activity, whilst ensuring that these resources are used economically, efficiently and effectively. This informs the detailed operational plans and budgets which are also approved by the Board. The plans are shared with the Membership Council and their views are taken into account by the Board prior to approval.

The Trust has also established quality improvement arrangements to ensure that resources are deployed effectively.

The Board agrees annually a set of strategic corporate objectives which are communicated to colleagues. This provides the basis for appraisals at all levels. The Board keeps operational performance and delivery against the objectives under constant review through scrutiny at each meeting of the Integrated Board Report covering patient safety, quality, access and experience metrics in addition to a finance performance report. In addition, detailed review of the quality aspects of the Integrated Board Report is undertaken each month by the Quality Committee. Additional financial scrutiny is also provided by the Finance and Performance Committee each month. The Trust has a Workforce Committee to provide more detailed scrutiny and assurance on workforce.

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. Assurances on the operation of controls are commissioned and reviewed by the Audit and Risk Committee and, where appropriate, the Quality Committee or other sub-committee of the Board of Directors as part of their annual cycle of business. The implementation of recommendations made by Internal Audit is overseen by the Audit and Risk Committee.

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. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Our Board of Directors takes an active leadership role on quality. The quality of our services is an integral part of our discussions on business matters and business decisions and the Board receives updates regularly. The Quality Committee terms of reference were reviewed and strengthened to focus on providing assurance on quality of services to the Board, supported by its revised governance structure. The Committee is a formal committee of the Trust Board and is chaired by a Non-Executive Director and includes two other Non-Executives, one of which has a clinical background. The Executive Director of Nursing, Executive Medical Director, clinical Divisional Directors and Assistant Divisional Directors of Nursing also attend the Committee.

The Quality Committee scrutinises the Integrated Board Report each month with a focus on the quality information within the report

There is clear clinical leadership for the development of the Annual Quality Report each year by the Executive Director of Nursing, in close collaboration with the Executive Medical Director. Both the Quality Committee and the Membership Council receive assurance on the progress against the priorities and outcomes highlighted within the Annual Quality Report. The Quality Committee is responsible for overseeing the production of the Annual Quality Report and for overseeing monitoring indicators and data quality. The Trust has engaged with its membership to develop the shortlist of quality priorities for 2018/19 and then tested these further with partner organisations, including Calderdale HealthWatch, Kirklees Healthwatch, NHS Calderdale Clinical Commissioning Group and NHS Greater Huddersfield Clinical Commissioning Group.

An unqualified limited scope assurance report was provided by external audit on the content of the quality report. They audited two national indicators – A&E 4 hour emergency care standard and 18 weeks and gave a qualified limited assurance opinion; and one local indicator – stroke care which received an unqualified limited assurance opinion.

The Quality Committee structured its work by the Care Quality Commission domains and took forward and evaluated safety, patient experience, clinical effectiveness and outcomes, and well led arrangements. The Quality Committee also seeks to learn from recommendations from national reports and inquiries. The Trust will continue to strive towards the provision of excellent service in response to these reports.

This work is supported by a range of policies, procedures and safe systems to promote staff engagement and ensure the implementation of key safety initiatives. This includes hand hygiene audits, exemplar ward reviews, safer surgery checklists, pressure ulcer audits and implementation of care bundles.

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 directors 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 Board and the Board sub-committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Board of Directors

The Board has set out the governance arrangements including the committee structure within the Standing Orders and its Constitution. The Chairs of the Board's sub-committees report to the Board at the first available Board meeting after each Committee meeting. Urgent matters are escalated by the Committee Chair to the Board as appropriate. The Board has agreed, in conjunction with the Membership Council, the strategic objectives for the Trust. The Executive Directors have assessed 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 Board Assurance Framework document reviewed regularly by the Board of Directors

Audit and Risk Committee

The Audit and Risk Committee is responsible for establishing 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. The Committee ensures that any recommendations from these audits are implemented. The Committee also reviews, on a regular basis, the risks that are described within the Trust's Board Assurance Framework. The Committee has oversight of, and relies on the work of the Risk and Compliance Group to monitor the risk management process and risk registers. The Committee also ensures that the Trust is meeting its corporate compliance requirements through a regular review of the compliance register, and has oversight of expressions of concern and whistleblowing arrangements. The Finance and Performance Committee is chaired by a Non-Executive Director and reports to the Board of Directors.

Quality Committee

The Quality Committee monitors selected quality metrics, and ensures that the Foundation Trust has robust systems in place to learn from experience. It receives reports from specialist governance committees e.g. Safeguarding: Information Governance; Patient Safety Group, Serious Incident Review Group and assures itself that Divisional Quality Boards are assuring themselves on the quality of their services. The Quality Committee is chaired by a Non-Executive Director and reports to the Board of Directors..

Finance and Performance Committee

The Finance and Performance Committee scrutinises the financial risks and targets and any significant risks to activity and performance. The Committee is responsible for ensuring that there are robust financial control procedures in place. The Finance and Performance Committee is chaired by a Non-Executive Director and reports to the Board of Directors.

Internal Audit

The Internal Audit reports issued in the year have given significant assurance that there is a generally sound system of internal control. However, some weakness in the design and/or inconsistent application of controls put the achievement of certain objectives at risk.

There were 29 completed internal audit reports in 2017/18. There were 20 reports with significant or full assurance. Nine internal audits received limited assurance. These were: Income from overseas visitors; compliance risk register; infection control; sepsis; consultant job plans; information governance toolkit; patient flow; agency controls and conflicts of interest.

Action plans and progress is reported in detail to each subsequent Audit and Risk Committee meeting as part of Internal Audit's follow up process. For the finalised reports there has been significant progress has been made in implementing the action plans in many of the individual audit report areas. Any areas where there has not been sufficient progress are called in for review by the Audit and Risk Committee. There have been no 'No Assurance' reports this year.

External Audit

External audit provides independent assurance on the accounts, annual report, Annual Governance Statement and on the Annual Quality Report.

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.

Significant matters in-year

The Trust had a number of significant matters during 2017/18:

- In August 2017 the Board approved a full business case for the proposed reconfiguration of hospital services for submission to NHS Improvement. This decision has been the subject of a judicial review case brought by Hands off HRI. An initial permission hearing in December found in favour of the Trust and permission was denied to progress the claim. The Claimants sought an appeal hearing which took place

in March 2018. At that hearing, the Judge allowed the claim to proceed on five of the eight grounds brought by the claimants. The full hearing is listed for 12-14 June 2018.

- In July 2017 the Joint Calderdale and Kirklees Overview and Scrutiny Committee (JOSC) referred the proposals to the Secretary of State for Health and Social Care who asked the Independent Reconfiguration Panel to review the referral. The IRP report was published on 11 May 2018 setting out the need for further work in three areas: out of hospital care; hospital capacity; and capital funding. The Secretary of State wrote to the commissioners and regulators asking for a report on progress in three months.
- Like many other Trusts, we had significant challenges in achieving the Emergency Care standard of the total time in A&E to be under four hours. We did not meet the national requirement for 95% of patients to be seen in A&E within 4 hours, achieving 90.6%. Achievement of the target was impacted upon by high attendance rates and significant daily variations in demand for non-elective services. The Health & Social care system was busy throughout the winter period with acuity increasing. The Trust was faced with an unprecedented surge in demand for non-elective care in December and January which required the Trust to operate fully in silver command and control mode with an OPEL 3 status for both sites. This continued throughout quarter 4. Winter pressures, flu season, staff shortages and norovirus all impacted on the Trust's resilience and ability to support patient flow.
- Recruitment and retention of medical staff into key specialties continues to be a challenge and has led to continued bank and agency use. The introduction of IR35 legislation has since placed additional pressure in particular specialties. A contingency plan has been developed for emergency care should gaps in staffing put the safety of the service at risk.
- The Trust has continued to undertake significant nursing recruitment both nationally and internationally. This has been successful, however, the need to open to additional capacity over the winter period placed pressure on nurse staffing which had to be addressed through bank and agency use.
- In May 2017 the Trust implemented a new Electronic Patient Record system across the organisation. This had a particular impact on our outpatient and appointments systems and resulted in a drop in activity during the first quarter of the year. Command and control arrangements were in place during the go-live period to ensure that any risks were clearly identified and mitigated. Specific digital operational and risk management processes have been implemented across all divisions to manage the impact going forward, including divisional digital boards with responsibility for digital risks.
- In March 2018 the Board of Directors approved the establishment of a wholly owned subsidiary for the provision of estates, facilities and procurement services. The company - known as Calderdale and Huddersfield Solutions Limited – will operate from the 1 September 2018 and will employ over 400 staff. There has been engagement with staff about the establishment of the company over the last 12 months and this will continue alongside formal consultation. There is significant work to do to ensure the company is ready to operate in relation to its governance arrangements, legal standing, contractual framework and the TUPE of staff prior to its launch in September.

Conclusion

The system of internal control has been in place in Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

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

Owen Williams
Chief Executive
23 May 2018

KPMG

Independent auditor's report

to the Council of Governors of Calderdale & Huddersfield NHS Foundation Trust

. REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Calderdale & Huddersfield NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity, Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

Material uncertainty related to going concern

We draw attention to note 1.1.2 to the financial statements which highlights events that indicate uncertainties concerning the ability of the Trust to continue as a going concern.

The Trust has incurred a significant deficit in year of £49.2m (2016/17: £13.8m). Loan borrowing has increased at the Trust, with loans from the Department of Health now totalling £103.9m (2016/17: £61.8m), with £15.7m due for repayment in the 2018/19 period. The Trust delivered £17.9m of Cost Improvement Programme (CIP) savings in 2017/18 against a plan of £20.0m.

The Trust has submitted a financial plan for 2018/19 that forecasts an operating deficit of £43.1m with a CIP delivery of £18m required in order to meet this target.

These events and conditions, along with the other matters explained in note 1.1.2, constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview		
Materiality: financial statements as a whole	£3.65m (2016/17:£3.7m) 1% (2016/17: 1%) of operating income	
Risks of material misstatement		**vs 2016/17**
Recurring risks	Valuation of land and buildings	◄►
	New: 2017/18 income	▲
Event driven	**New:** Electronic Patient Records asset valuation	▲
	New: Estates Special Purpose Vehicle	▲

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

	The risk	Our response
Property, Plant & Equipment (£220 million; 2016/17: £234m) *Refer to the Audit & Risk Committee Report within the 'Directors' Report' in the Trust's Annual Report and Accounts, Section 1.7 of Note 1 to the Accounts (accounting policies) and Note 16.1 to the accounts (Property, Plant & Equipment disclosures).*	**Subjective valuation: land and buildings:** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to Calderdale Royal Hospital in Halifax and Huddersfield Royal Infirmary. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Trust consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. Generally valuations should be gross of VAT. However, circumstances may arise where the asset would be more appropriately valued net of VAT. For instance, entities may recover VAT on payments for the provision of a fully managed and serviced building under a PFI. The valuation of the land & buildings is completed by the District Valuer, an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Full valuations are required to be completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. Calderdale & Huddersfield NHS Foundation Trust had a full valuation undertaken at 31 March 2015, and an interim valuation performed at 31 March 2018. The result of the valuation at 31 March 2018 was an increase of £9.9 million in the value of the land & buildings. Overall the Trust's Property, Plant & Equipment have reduced in value by £15m from 2016/17 reflecting the transfer of assets to the Special Purpose Vehicle company and the reclassification of the Electronic Patient Records system to an intangible asset.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the scope, qualifications and experience of the Trust's external valuer to confirm they were appropriately experienced and qualified to undertake the valuation, and we considered whether the overall valuation methodology was in line with industry practice, the Department of Health. Group Accounting Manual and the Trust's accounting policies; — **Data comparisons:** We considered whether the information provided to the valuer by the Trust, relating to the assets requiring to be valued, including details of in-year capital expenditure, changes in use and land area and floor space, was complete and agreed to the Trust's fixed asset records; — **Methodology choice:** We critically assessed the appropriateness of the assumptions used in the valuer's calculations, especially cost indices and underlying replacement cost assumptions, based on our own expectations by reference to sector and local knowledge; — **Assessing transparency:** We assessed the treatment of the revaluation within the Trust's financial statements to ensure that any upwards revaluations or impairments had been properly classified and accounted for and complied with the requirements of the Group Accounting Manual; and — **Tests of detail:** We tested a sample of items of capital expenditure in 2017/18 to confirm that the additions were appropriately valued in the financial statements.

2. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
NHS and non-NHS income (£360 million; 2016/17: £375m) *Refer to the Audit & Risk Committee Report within the 'Directors' Report' in the Trust's Annual Report and Accounts, Section 1.4 of Note 1 to the Accounts (accounting policies) and Notes 3 and 4 to the accounts (Operating income from patient care activities and Other operating income disclosures).*	**2017/18 income:** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up over 96% of income from activities. Income from NHS England and CCGs is captured through the Agreement of Balances exercises performed at months 6, 9 and 12 to confirm amounts received and owed. Mismatches in income and expenditure, and receivables and payables are recognised by the Trust and its counterparties to be resolved. Where mismatches cannot be resolved they can be reclassified as formal disputes.	Our procedures included: — **Tests of details**: We undertook the following tests of detail: — We compared the actual income received from the Trust's CCG commissioners against the contracts agreed at the start of the year. We agreed any significant variations between the actual income and the agreed contract to signed contract variations and other correspondence agreement the variation to the contract; — We critically assessed the output from the Department of Health's Agreement of Balances exercise. We obtained evidence and explanations regarding the Trust's recognition of their income, where the output indicated the Trust's income was not matched by corresponding expenditure in other NHS organisations' accounts; — We agreed the receipt and recognition of Sustainability and Transformation Funding monies to correspondence from NHS Improvement; — We agreed a sample of other income to supporting documentation to assess whether the income was correctly recognised in 2017/18; — We agreed a sample of income received in March and April 2018 to supporting documentation to assess whether the income had been accounted for in the correct financial year.

2. Key audit matters: our assessment of risks of material misstatement

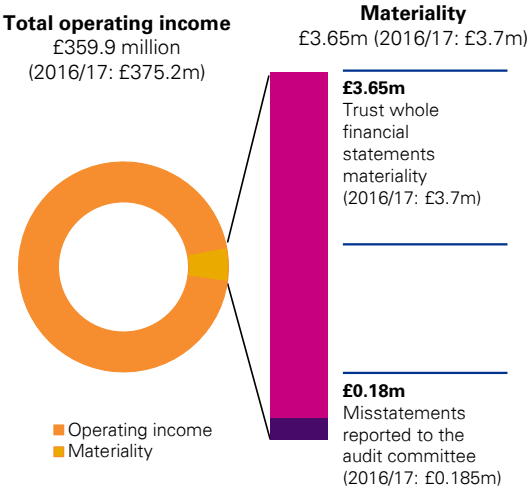
	The risk	Our response
Electronic Patient Records (EPR) (Within Intangible Assets £7.4 million; 2016/17: £15m included in Assets under Construction in Property, Plant & Equipment) *Refer to the Audit & Risk Committee Report within the 'Directors' Report' in the Trust's Annual Report and Accounts, Section 1.8 of Note 1 to the Accounts (accounting policies) and Note 15.1 to the accounts (Property, Plant & Equipment disclosures).*	**Accounting valuation and treatment:** The Trust has now fully implemented the EPR system which went live in May 2017. In addition to the costs capitalised in the previous years during the design and testing stages, the Trust have capitalised costs during the implementation phase relating to the cost of bringing the asset into use. The amount of cost capitalised in 2017/18 is £5.4m. In addition, the Trust have impaired the value of the EPR asset so that it reflects the actual fair value. The value of the impairment in year was £14.4m and the valuation of the asset was £4.3m.	Our procedures included: — **Tests of detail:** We tested a sample of items of capital expenditure in 2017/18 to assess whether the additions were correctly related to bring the asset into use, and were appropriately valued in the financial statements; — **Methodology choice:** We critically assessed the valuation of the EPR system and the Trust's assumption of impairment; and — **Assessing transparency:** We assessed the treatment of the asset valuation within the Trust's financial statements, and assessed whether the impairments had been properly classified and accounted for in compliance with the requirements of the Group Accounting Manual.
Estates Special Purpose Vehicle (SPV) (Within Property, Plant & Equipment £220 million; 2016/17: n/a) *Refer to the Audit & Risk Committee Report within the 'Directors' Report' in the Trust's Annual Report and Accounts, Section 1.7 of Note 1 to the Accounts (accounting policies) and Note 16.1 to the accounts (Property, Plant & Equipment disclosures).*	**Estates Special Purpose Vehicle (SPV):** During December 2017 the Trust Board approved a business case to set up a Special Purpose Vehicle (SPV) for Estates and Facilities services. The Trust Board agreed to transfer Trust estate assets, excluding those relating to the Private Finance Initiative financed Calderdale Royal Hospital, to the SPV. The creation of the SPV should be recorded appropriately in the Trust Accounts in line with accounting guidance. Following the decision to transfer the assets to the SPV, the Trust revalued the assets to reflect that they exclude VAT. The Trust have also included £1.5m of income relating to a claim from HMRC under the Capital Goods Scheme.	Our procedures included: — **Assessing valuer's credentials:** We critically assessed the scope, qualifications and experience of the Trust's external valuer to confirm they were appropriately experienced and qualified to undertake the valuation, and we considered whether the overall valuation methodology was in line with industry practice, the Department of Health. Group Accounting Manual and the Trust's accounting policies; — **Data comparisons:** We considered whether the information provided to the valuer by the Trust, relating to the assets requiring to be valued, including details of in-year capital expenditure, changes in use and land area and floor space, was complete and agreed to the Trust's fixed asset records; — **Methodology choice:** We critically assessed the appropriateness of the assumptions used in the valuer's calculations, especially cost indices and underlying replacement cost assumptions, based on our own expectations by reference to sector and local knowledge; — **Assessing transparency:** We assessed the treatment of the revaluation within the Trust's financial statements to ensure that any upwards revaluations or impairments had been properly classified and accounted for and complied with the requirements of the Group Accounting Manual.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £3.65 million (2016/17: £3.7 million), determined with reference to a benchmark of total operating income (of which it represents approximately 1%). We consider operating income to be more stable than a surplus or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.18 million (2016/17:(£0.185 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Huddersfield.



4. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

— we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or

— the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or

— the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, 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 have nothing to report in these respects.

5. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out in the Statement of Chief Executive's Responsibilities, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

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REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Other matters on which we report by exception – adequacy of arrangements to secure value for money

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Adverse conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Calderdale & Huddersfield NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

In considering the Trust's arrangements for securing financial resilience and its arrangements for challenging how it secures economy, efficiency and effectiveness in the use of its resources we identified the following:

– the Trust incurred a deficit for the year of £48.6m in 2017/18 and has a cumulative negative Income & Expenditure Reserve of £114.1m as at 31 March 2018;

– the Trust has not accepted its control total of a £22.6m and has set a financial plan of a £43.1m deficit for 2018/19, this includes a cost improvement programme target of £18.0m;

– the Trust does not have sufficient cash to meet its commitments without receiving further external funding; and

– current borrowing (over and above PFI related borrowing) totals £103.7m at 31 March 2018 (£61.7m at 31 March 2017), with £15.7m of this falling due prior to 31 March 2019. The cash borrowing requirement for 2018/19 is planned to be £43.1m.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

KPMG

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	As part of our responsibilities in relation to reaching our use of resources conclusion we are required to perform any work that we regard as necessary to allow us to conclude on whether the Trust has effectively, efficiently and economically exercised its functions. Due to the significant financial challenge in the sector and financial support the Trust has received from the Department of Health, and the enforcements actions that have been reported against through the year, as a result of having been in breach of your licence for financial reasons, we have undertaken a detailed consideration of the financial position and financial sustainability.	Our work included: **Financial Sustainability:** We performed work to assess the Trust's financial sustainability. This considered whether the financial results included significant non-recurring items of income within the reported headline result. We also considered the Trust's management of its cash position and delivery of CIPs through the year. **Financial Support:** Our work considered the nature of financial support the Trust has received from the Department of Health and progress made against enforcement actions in relation to the financial position. We have also considered compliance with the agency spending caps where mandatory. **Future forecasts:** We have considered the future financial forecasts for the Trust. This included: – Performing an analysis of the Trust's forecast run rate position; – Considering the core assumptions in the Trust's 2018/19 Annual Plan submission; – Considering the extent to which recurrent cost improvement schemes were achieved in 2017/18 and identified for 2018/19; and – Reviewing the number of material contracts with commissioners which have been agreed for 2018/19 and the supporting risk analysis reported to the Board. **Findings from our work:** The findings from our work are: – the Trust deficit for 2017/18 was £48.6m, and the cumulative negative Income & Expenditure Reserve is £114.1m as at 31 March 2018; – the Trust has not accepted its control total for 2018/19 of a £22.6m deficit and has set a financial plan of a £43.1m deficit, this includes a cost improvement programme target of £18.0m which reflects over 5% of planned expenditure; – the Trust does not have sufficient cash to meet its commitments without receiving further external funding; and – current borrowing (over and above PFI related borrowing) is £103.7m at 31 March 2018 and has increased by £42m in the year, with £15.7m of this falling due prior to 31 March 2019. The cash borrowing requirement for 2018/19 is planned to be an additional £43.1m, which would leave the total borrowing at 31 March 2019 at £146m. As a result of these matters, we are unable to satisfy ourselves that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Calderdale & Huddersfield NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Clare Partridge
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
1 Sovereign Square, Sovereign Street,
Leeds, LS1 4DA
24 May 2018


NHS

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Calderdale and Huddersfield

NHS Foundation Trust

Quality Account 2017/18

compassionate care

Part 1: Chief Executive's Statement

Welcome to the 2017/18 Calderdale and Huddersfield NHS Foundation Trust (CHFT) Quality Account.

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

In March 2018 we had unannounced Care Quality Commission visits which were followed by a planned three-day inspection in April 2018 and we await their new rating. We were able to demonstrate trust-wide all the developments since their last visit when 70% of our services were rated as "good", yet overall we received a rating of "requires improvement" which was in line with all other West Yorkshire Trusts.

In April 2018 a High Court judge ruled that our Full Business Case for the health reconfiguration proposals should go to a Judicial Review and this is now due to be heard in June 2018. A decision from the Health Secretary will follow the outcome of that hearing.

As I write, we are emerging from what has been accepted as what has been widely acknowledged as the stand-out winter for the NHS. After a hugely challenging December and January, the "Beast from the East" struck in February. For us it meant extra beds and wards opening to cope with the high numbers of very poorly patients.

It also brought out the very best from colleagues at CHFT who pulled out all the stops to be able to provide compassionate care to our patients.

As a result we were again in the top 10% of best performing Trusts in the country for achieving the targets for emergency care – something we could not have achieved without close working with our partners in social care and in community.

That is the general overview of our performance for this year. In this section you will witness a more detailed appraisal of all the hard work under way to maintaining safe, quality care. This is always top of the agenda for our Board of Directors and in this increasingly challenging financial environment, combined with increased demands for our services, it is even more important to ensure that any changes we make are assessed for their impact on quality before they are able to go ahead.

There are some excellent examples of high quality care and services across all of our community and hospital services. I hope you will find the following pages informative and helpful in giving you an insight into the vast amount of improvement work we continue to do in the Trust.

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

Owen Williams, Chief Executive, May 2018

Part 2: How the Trust performed against the three priorities set for 2017/18

Each year the Trust works on a number of quality priorities. Last year the Trust identified three projects to be highlighted as key priorities for 2017/18.

This section of the Quality Account shows how the Trust has performed against each of these priorities and the plans going forward.

Improvement Domain	Improvement Priority	Were we successful in 2016/17?
Safety	Sepsis Screening	Yes
Effectiveness	Discharge Planning	Yes
Experience	Learning from Complaints	Yes

Priority One – Sepsis Screening for in patients

Sepsis is an infection which starts in one part of the body but spreads via the blood and can prove fatal for some patients.

It is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are thought to contribute to a number of preventable deaths.

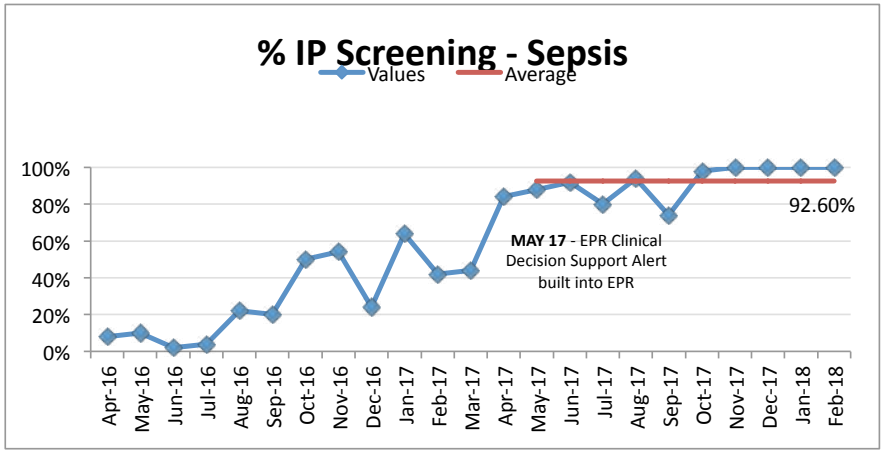
Improvement work
The Trust looked to improve the recognition of potential sepsis through a number of interventions. One key intervention centres on ensuring appropriate screening of patients with suspected sepsis. This screening will enable patients to commence treatments sooner and improve their overall outcomes. This is important for patients both arriving with us with sepsis and those that develop sepsis whilst under our care.

There has been significant process changes with the introduction of the Electronic Patient Record (EPR) in May 2017 with further developments anticipated later this year. Previously CHFT used the clinical criteria of a national early warning score (NEWS) greater than 5 to alert the clinical team to assess for sepsis using the sepsis screening bundle (evidence based interventions for sepsis) in the medical records. A second bundle supported clinicians to recognise and manage severe sepsis.

We have held a number of focus groups with our doctors and nurses to understand what barriers get in the way of recognising and responding to sepsis. This has helped us tailor the right actions to support our doctors and nurses caring for patients with sepsis to ensure our patients are treated in a timely manner.

How did we do?
With the Cerner EPR now in place, CHFT continuously monitors and "screens" inpatients for possible sepsis using a criteria with clinical and laboratory measures. If three clinical parameters, or two clinical parameters and one laboratory measurements are abnormal the system will trigger an alert to the clinical team to consider whether sepsis is present. If severe sepsis is identified the team are prompted to request and complete the adult sepsis 6 care plans which includes further investigations along with prescriptions for fluids and antibiotics.

This has resulted in a significant improvement over the last 12 months in ensuring patients are screened for sepsis. As demonstrated in the chart below, we have exceeded our target of 90% of inpatients being screened.



Priority Two – Discharge Planning

Why we chose this

Safe and timely discharge planning is an important part of the inpatient stay. It is estimated that over 20% of discharges require some complex planning and coordination. In order to ensure that these patients have a safe and appropriate environment to return to after their stay, the Trust developed and further enhanced the role of the discharge co-ordinator, so that these roles continue to be effective and work collaboratively with our partners

Improvement work

Whilst the role of the Discharge Coordinator is pivotal to the continued improvement of safe and timely complex discharges, this is as a part of a wider programme of work that involves forging close and effective partnerships with partners in the local authorities to understand the needs of patients who are medically ready for discharge. We are carried out internal improvement work to make sure our patients can reach their optimum before discharge, primarily through our Frailty Team and by providing more services in the community to keep people fit and able to self-care, often avoiding admission in the first instance.

The work in 2017/18 is a continuation of a transformational piece of work started by the Trust in 2016/17 and will continue into 2018/19.

How did we do?

As shown in the chart below there has been a sustainable reduction in patients with an over 50 day length of stay. This is due to dedicated discharge teams having worked with local authority partners over the last 12 months and focussing on reducing longer stay and medically stable patients.

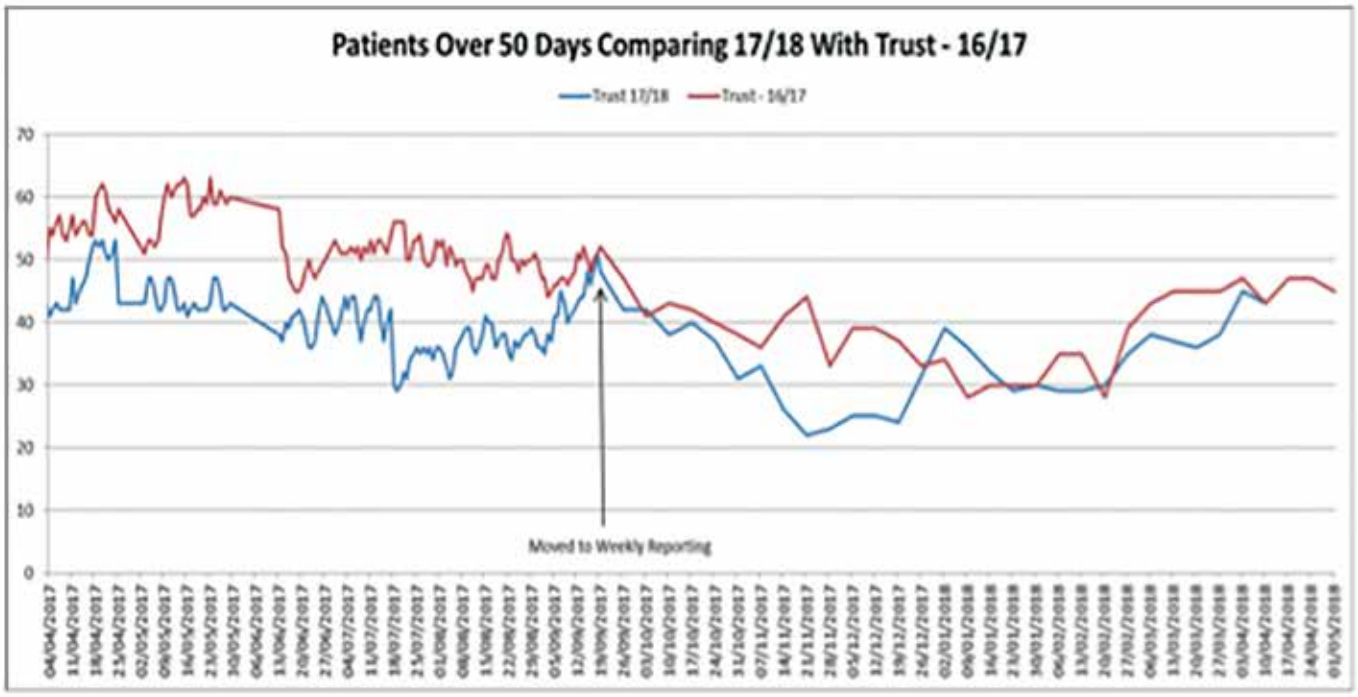


Chart 2: Patients with a Length of Stay greater than 50 days

Discharge Improvements in 2017/18 included the following eight schemes that were initiated to improve discharge as part of the SAFER programme:

- Introduction of a new reablement pathway.
- Tracking and expediting of complex pathways
- Implementation of a new non-weight-bearing discharge pathway
- Introduction of ward based social workers
- Equipment task and finish group
- Implementation of criteria led discharge
- New continuing healthcare assessment process
- Readmission- New cellulitis pathway.

All of these initiatives have been introduced or implemented; some are now well established for example the new reablement pathway was introduced September 2017. Prior to implementation of the new reablement pathway the average time from referral to discharge was 12 days; the new pathway has reduced this to an average of 4 days. A similar improved position is seen with the new continuing care pathway reducing the length of the pathway from over 10 days to 2 days. Other initiative have been more recently implemented and are in the early phase for example criteria led discharge, this has been established on two wards and is about to be rolled out further.

The Integrated Discharge Team, which includes CHFT discharge coordinators, discharge sisters, therapists and matron and the local authority social care team were successful in winning the CHFT Celebrating Success 'Four Pillars Award' and the Gordon Mclean Award for the sustainable improvements they have achieved over the last year in improving discharge planning, reducing the length of stay patients with complex needs and the positive impact this has on those patients and families.

This work to improve discharges will continue through the SAFER programme. Improving hospital flow is a quality account priority for 2018/19 with further details given on page 124.

Priority Three – Learning from Complaints

Why we chose this

We receive a lot of positive feedback on our services throughout the year. However, when our patients are dissatisfied with the service they receive and make a formal complaint, we act on it. It is critical that we learn from patients' experiences of our services and make improvements. We plan to improve the quality of the response to complaints and increase learning from complaints.

Improvement work

The Parliamentary Health Service Ombudsman's report, Learning from Mistakes, July 2016, reiterated that training and accrediting sufficient investigators is crucial to improve learning from investigations. Therefore a new training package has been devised in Q4 of 2016/17 for complaints investigators, with a 2017/18 training programme of dates to support staff in their investigative approach to patient complaints. This training will incorporate the process of how to ensure good quality investigations are undertaken and that the tools for capturing and disseminating learning are known.

Learning from complaints is closely linked to learning from incidents that have caused severe or moderate harm. Having a culture where the expectation is to learn, no matter what happened is key as well as involving patients and families. The work on learning from complaints takes place in the context of the recently developed framework on learning from adverse events, based on a staff survey and focus groups with staff on learning. This identified actions around the methods we use to share learning across the organisation, promoting a safety and learning culture and training.

How did we do?

Complaints Training

A one day complaints training package for staff was developed and introduced in 2017/18 to support staff in undertaking effective complaints investigations. This was a full day course looking at the legislation behind NHS complaints, tools and techniques for investigating a complaint, how to identify and disseminate learning from a complaint.

76 members of staff have been trained in complaints management, attending this course during 2017/18. Positive feedback was received from the evaluation, with attendees feeling more confident in managing complaints, understanding the need to plan and structure the investigation and increased awareness of the requirements for complaints responses and legislative requirements.

On reviewing the course evaluation forms the team has reviewed the complaints training package and is moving from a full day course to a five module training course. This will be introduced in 2018 and will enable more staff to take up the training as the training is split into five modules.

Identifying and Sharing Learning from Complaints

To ensure that learning from complaints is shared with staff in as many ways as possible, learning has been shared in line with the Trust learning framework as detailed further below. This includes:

- Revised Complaints Policy confirming the importance of identifying learning from complaints and governance arrangements / responsibilities for learning from complaints within divisions
- Monthly reports within divisional quality and safety forums
- Quarterly complaints reports
- Shared Learning Improving care - "Focus On…. newsletters
- Team newsletters
- Bite size chunks learning
- Complaints panels with two divisions to ensure all responses capture learning where appropriate

Further detail on a number of these is given below:

Managers from the complaints team undertook a "go see" visit to Morecambe Bay Hospital in September 2017 and during this visit explored how the Trust identifies learning from complaints. The approach taken to identifying learning from complaints at Morecambe Bay was similar to that used within the Trust, through quarterly and an annual complaints report.

Within the Trust, complaints learning is shared within the complaints quarterly report (section 5) which is presented to the Patient Experience Group, with patient experience representatives from each division. This report includes complaints learning from each division and learning from the

Parliamentary and Health Service Ombudsman (PHSO) in the quarter. A new section was added during the year called "featured learning" where learning from a particular complaint is included.

Divisional representatives share learning from complaints within the Divisions, as well as reporting on learning from complaints within the Patient Safety Quality Boards and their reports to the Quality Committee.

In addition to routinely capturing learning from complaints as part of the management of a complaint, as part of the Trust's learning framework, learning from complaints also features in the "Sharing Learning – Improving Care " newsletters, e.g. Focus on Dementia . These newsletters are shared with all ward and outpatient areas and within the Trust staff newsletter.

The Trust has developed and promoted a Shared Learning – Improving Care intranet page during the year. The "Focus on…" newsletters and bite-sized learning from adverse events including complaints are all accessible to staff on this intranet page.

One area that was identified from an internal audit report on complaints and the "go see" visit to Morecambe Bay was the need to seek user feedback on the complaints process. In March 2018 the first electronic surveys of users was commenced, using a pilot survey in Morecambe Bay and the NHS Improvement Complaints Survey Toolkit. The survey gathered views from complainants on their experience of the complaints process via an electronic survey tool. To date response rates have been encouraging and the surveys will be extended during 2018. Information received from the survey will be analysed to identify areas of improvement for handling complaints during 2018.

An internal audit report on complaints handling identified the need for more specific learning to be identified from complaints and for this to be shared across divisions. In response to this the quality assurance process for reviewing complaints has been strengthened, with gaps in identifying learning highlighted as part of the review process. Joint weekly complaints review panels, with managers from the central complaints team and the Surgery and Anaesthetic Division and Medical Division were introduced towards the end of quarter 3. Each complaint is discussed in detail with the lead investigator and as part of this checks are made to ensure that learning is clearly described in the complaint. Where learning has not been identified in the complaints response further work is undertaken to include the learning that has taken place following a complaint.

One theme identified from complaints during 2017/18 was communication within the Emergency Department. A "Go See" visit of the Emergency Department during a nightshift (19:30 – 05:30) by the Complaints Manager took place to identify issues that staff are facing in de-escalating complaints and general customer service techniques. As a result a workshop on customer service has been developed and the first of these sessions was delivered in February 2018, with further sessions planned for 2018.

A sample of learning from complaints during 2017/18 is given later in the report in the complaints section.

A complaints improvement plan for 2018 - 20 has been developed and this will continue the work to improve learning from complaints and improve patient experience and services. Further details of this work is given on page 64 of this report.

Looking ahead to 2018/19

A 'long list' of potential priorities for 2018/19 was developed from the following sources:

- Regulator reports,
- Incidents and complaints,
- On-going internal quality improvement priorities,
- National reports and areas of concern,
- Evaluating the Trust's performance against its priorities for 2017/18,
- Membership Council workshop.

This long list was discussed with the Trust's Membership Council; an opportunity to vote was also given via the Trust's internet site advertised in Foundation Trust News which is circulated to the Trust membership. This work has helped identify the following quality improvement priorities for 2018/19.

All previous priorities will continue to be monitored as part of the Trust's on-going improvement programmes.

The three priorities for 2018/19 are:

Domain	Priority
Safety	Care of the Acutely Ill Patient: Improving outcomes through recognition, response and prevention of deteriorating patients
Effectiveness	Patient Flow: Managing Complex Discharges
Experience	End of Life Care: Improving the experience of care for those patients who are being managed at the end of life.

Priority One: Care of the Acutely Ill Patient: improving outcomes through recognition, response and prevention of deteriorating patients

Why we chose this

Timely recognition and response to a patient's changing needs can make a difference in their clinical outcomes and their overall experience of care. The Trust has an established Deterioration Programme which is subdivided into key areas of focus namely recognition, response and prevention of deterioration in inpatients.

Within each subheading there are separate work streams that are thought to be significant enablers for improvement. Since the implemented of a number of electronic systems the Trust is able to gain ever more meaningful insights in to the way patients are cared for.

Improvement work

The Deterioration Programme continues to focus on the recognition, response and prevention of deterioration in patients. Quality improvement (QI) continues to focus on timely and quality observations, timely response to patients with an elevated National Early Warning Score (NEWS) and optimisation of both safety huddles and EPR.

To specifically address the response element of the programme, a real time audit of patients who scored a NEWS of 5 or more is being carried out. This is to be performed on both 'in' and 'out' of hour's patients and the learning form this will form part of the 2018/19 improvement plan going forward.

Reporting

Reporting on this priority will be through the Clinical Outcomes Group and the Deteriorating Patient Group.

Priority Two: Patient Flow – Improving Timely & Safe Discharge (right patient, right place, right time)

Why we chose this

On average, every day in CHFT acute hospitals eight people become ready for discharge but need ongoing services to make their discharge safe and appropriate. Management of these patients is an organisational priority, both from a patient safety and experience viewpoint, and also an organisational efficiency perspective. The discharge process is often a complex collaborative plan with multiple agencies.

Any delay in the discharge pathway can mean increased risk of de-compensation of patient condition and an expediential increase in length of stay (LOS), unrelated to original reason for admission. A proportion of these patients may become reportable to NHSE as 'Delayed Transfers of Care', a key metric for Trust performance.

The management of these patients has become

a priority and has been a key focus of the SAFER Patient Transformational Flow Programme led by the Director of Urgent Care.

The key performance and quality indicators are:
1. Number of patients with a LOS over 50 days- target for 2018/19 is <30 patients
2. Number of medically fit for discharge patients- target for 2018/19 is <80 patients
3. Length of stay of patients over 75 years- target for 2018/19 is <7 days

Improvement work
The improvement work that commenced in 2016/17 surrounding the management of the patients with a complex discharge need is established. The evidence shows that this work has been successful and enhancing the capabilities of the discharge coordinators through the trusted assessor route with the aim of reducing the length of the complex discharge pathways is the main focus.
CHFT will also hold a multi –agency discharge event (MADE Event) to improve discharge planning, supported by the Emergency Care Improvement team.

Reporting
Performance against key performance indicators (KPIs) are measured and reported to the monthly SAFER Patient Flow Board. This Board reports into the Transfer of Care Board and A& E Delivery Board.

Priority Three: Improve experience of patients on care of the dying pathway

Why we chose this
Improving end of life care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die, when their death is expected, it is vital that they receive appropriate end of life care.

The Trust is looking to sensitively establish that during these times a patients relatives felt that the needs of their loved one were meet in a compassionate and appropriate way.

Improvement work
The Trust will be linking into the Learning from Deaths work (see page 21 to test a short bereavement survey.

Reporting
Reporting on End of Life Care will be to the Clinical Outcomes Group.

Statements of assurance from the Board

Review of services

During 2017/18 Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 36 designated Commissioner Requested Services.

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

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health services by Calderdale and Huddersfield NHS Foundation Trust for 2017/18.

Participation in Clinical Audit
During 2017/18, 52 of the national clinical audits and three national confidential enquiries covered relevant NHS services provided by Calderdale and Huddersfield NHS Foundation Trust.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 91% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. These are detailed in Appendix A.

Participation in clinical research
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 the Trust in 2017/18 that were recruited into trials during that period to participate in research approved by a research ethics committee was 1491 (as at end of February 2018).

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

The Trust was involved in conducting 92 clinical research studies all of which were actively recruiting (excludes student and Participant Identification Centre - PIC studies), 33 were closed to recruitment (but participants were still involved) and 19 recruiting studies were commenced. A further 22 studies were undergoing 'capacity and capability assessment'.

During 2017/18 actively recruiting research studies were being conducted across four of the five divisions in twenty six specialties:

- Families and Specialist Services , 16 studies, 8 specialties
- Corporate, study
- Medical Services, 68 studies, 13 specialties
- Surgical and Anaesthetic Services, 7 studies 5 specialties

There were 85 clinical staff (supported by 15 non clinical staff) participating in research approved by a research ethics committee at the Trust during 2017/18, of which 44 were local principal investigators, 1 was a chief investigator on a qualitative study,

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

Learning From Deaths
During 2017/18, 1729 of CHFT adult inpatients died.
This comprised the following number of adult deaths which occurred in each quarter of that reporting period:

384 in the first quarter;
386 in the second quarter;
434 in the third quarter;
525 in the fourth quarter

The current process for learning from adult deaths in the trust includes reviewing cases notes using an initial screening review (ISR) tool to assess the quality of care and structured judgement reviews (SJR) which assesses quality of care and avoidability concerns. Cases that are assessed with either poor or very poor care are escalated for a more in depth SJR. Some case are escalated for a structured judgement review without an ISR and

these cases include deaths in elective patients, patients with learning disabilities, complaints from relatives or carers.

Adult deaths
By April 2018, 478 case record reviews and 20 investigations have been carried out. The investigations are the cases that had been reported on the incident reporting system (Datix) as either a red or orange incident.

All deaths that were subject to an investigation also had case record review at the structured judgement review level. The number of deaths in each quarter for which a case record review was carried out was:
70 in the first quarter;
90 in the second quarter;
154 in the third quarter;
164 in the fourth quarter.

Six (0.35%) of the patient deaths during the reporting period are judged to be more likely than not, to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
1 case (0.27%) for the first quarter;
2 cases (0.59%) for the second quarter;
2 cases (0.47%) for the third quarter;
1 case (0.19%) for the fourth quarter

These numbers have been estimated from data collected from the ISR and SJR.

A further 62 case record reviews and 4 investigations were completed after 1stApril 2017 which related to deaths which took place before the start of the reporting period (in 2016/17 period).

Two cases representing 3.2% of the patient deaths before the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the ISR and SJR process although the terminology was previously referred to as 1st and 2nd level mortality reviews.

Six representing 0.35% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient compared to the 5 representing 0.73% of the total patient deaths in 2016/17.

Deaths in 0 to 18 year olds
Deaths of all children from birth to 18 years in the area are notified to the Calderdale and Kirklees Safeguarding Children Boards Joint Child Death Overview Panel (JCDOP).

During 2017/18, 13 of CHFT's paediatric inpatients died

This comprised the following number of child deaths which occurred in each quarter of that reporting period:

7 in the first quarter;
0 in the second quarter;
4 in the third quarter;
2 in the fourth quarter

By April 2018, all 13 cases a case record review and 2 investigations have been carried out.

Deaths that were subject to an investigation are included in the case record review numbers. The number of deaths in each quarter for which a case record review was carried out was:

7 in the first quarter;
0 in the second quarter;
4 in the third quarter;
2 in the fourth quarter

Due to the nature of the child case record review process it is not possible to report the number of deaths which were more likely than not, to have been due to problems in the care provided. Each case is written as a narrative summary as opposed to being given a discrete avoidability score.

Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2017/18 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

For CCG's and NHSE – Direct Services the 2017-19 National CQUIN Guidance split the usual 2.5% CQUIN funding as follows

- 1.5% agreed scheme indicators
- 0.5% to support engagement with service transformation plans (STPs)
- 0.5% linked to risk reserve

For NHSE – Specialised the 2017-19 National CQUIN Guidance split the usual 2.0% CQUIN funding as follows

- 2.0% national indicators

The contract value for CQUINs in 2017/18 was £6.74m (£6.41m for CCG's and £0.33m for NHS England).

The schemes were as follows:

CQUIN		Community or Acute
1.	Improving Staff Health and Wellbeing	Acute
2.	Reducing the impact of serious infections (Antimicrobial resistance and Sepsis)	Acute
3.	Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)	Acute
4.	Improving services for people with mental health needs who present to A&E	Community
5.	Offering Advice and Guidance	Acute
6.	e-Referrals	Acute
7.	Supporting proactive and safe discharge	Acute
8.	Preventing ill health by risky behaviours – alcohol and tobacco	Acute
9.	Improving the assessment of wounds	Community
10	10.Personalised care and support planning	Community

Further details of the nationally agreed goals for 2017/18 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The Trust did not fully achieve the following:

- 1% reduction in antibiotic prescribing
- Risky Behaviours (Alcohol and Tobacco Screening)
- Sepsis antibiotic within an hour

The Trust had a year-end settlement with its main commissioners, NHS Calderdale CCG, NHS Greater Huddersfield CCG and NHS England – Specialised based on full achievement of CQUIN. The actual value of CQUIN achieved in 2017/18 therefore was £6.67m.

Compared to 2016/17 when the CQUIN achievement amount was £6.92 million.

Care Quality Commission registration
The Trust is required to register with the Care Quality Commission (CQC) and has full registration without conditions.

As noted in the Chief Executive's statement, Calderdale and Huddersfield Foundation Trust has participated in unannounced CQC visits in March 2018 ahead of a planned inspection in April 2018. This included visits to the following core services: Community inpatients, Emergency Department, Critical Care, Children's and Young Peoples Services, maternity and Community Sexual Health. Following the inspection a rating will be given and actions will be taken to address the conclusions or requirements reported by the CQC.

The CQC carried out an inspection of the Trust between 8th and 11th March 2016 as part of their comprehensive inspection programme. In addition, unannounced inspections were carried out on 16th and 22nd March 2016. The Trust was rated as requires improvement overall.

The reports from the CQC inspection were published on their website in August 2016 and can be found at the following link: http://www.cqc.org.uk/provider/RWY

The judgements made by the CQC following their inspection relating to the Trust overall were:

Overall rating for this Trust:	**Requires Improvement**
Are services at this Trust safe?	Requires improvement
Are services at this Trust effective?	Requires improvement
Are services at this Trust caring?	Good
Are services at this Trust responsive?	Good
Are services at this Trust well-led?	Requires improvement

The CQC is currently carrying out checks on the locations registered by CHFT using their new way of inspecting services, reports will be published when the checks are complete.

Calderdale and Huddersfield Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.
Calderdale and Huddersfield Foundation Trust has made the following progress by 31 March 2018 in taking such action. An end of year report to the Quality Committee and Board of Directors detailed the Trust response to the CQC inspection report and the concerns raised at the time of the inspection. It provided a year-end position against all of the must and should do actions and how the plan has been managed, including the role of the CQC Response Group and ongoing discussions with the CQC management team. The arrangements for the ongoing management of the CQC inspection requirements is monitored through the Risk and Compliance group which reports to Audit and Risk Committee.

Data Quality
The Trust submitted records during 2017/18 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 = 100%
Accident & Emergency Care = 99.2%

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

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

These figures are based on April 2017 to December 2017, which are the most recent figures in the Data Quality Dashboard.

The Trust successfully implemented the Cerner Millennium Electronic Patient Record (EPR) in May 2017. As part of this implementation the Trust also implemented the Cymbio Data Quality dashboard, which was recommended by other Cerner Millennium EPR sites. The Dashboard provides a view of operational performance in near real-time, highlighting under-performance, operational inefficiency, issues and bottlenecks. The dashboard indicators have drill-down functionality at Trust, site, division, specialty and department, ultimately down to the detailed patient activity record as required. A RAG status is reported for each indicator based on deviation from levels commonly defined from historical baseline data.

A number of specific data quality KPIs were agreed as priorities and the delivery of progress against these is monitored at the Trust's fortnightly Data Quality Group. This group actively scans for any new issues and responds to these as required, supported by the Cymbio Dashboard.

The structure for data quality information team has also been reviewed and recommendations made to ensure that adequate resource and oversight is maintained. In the initial months following deployment the Trust employed experts from Cymbio to help advise and train staff, including working closely with the internal data quality team to provide guidance, documentation and support in corrective actions required to ensure data is accurate and fit for purpose.

Information Governance
The Trust Information Governance assessment report overall score in October 2017 was 71% and graded as green, 'satisfactory' with all scores at a level two or three. The Trust achieved 73% compliance in March 2018.

There have been online and face to face awareness raising 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.

Staff are mandated to complete the Information Governance training on a yearly basis through the electronic staff record, ESR, in addition to this from January 2018 face to face overview sessions have been run to raise awareness on the General Data Protection Regulation (GDPR) which comes into force on 25 May 2018.

Clinical Coding Error Rate
Calderdale and Huddersfield Foundation Trust were not subject to the Payment by Results clinical coding audit during 2017/18.

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.

The NHS Outcomes Framework 2016/17 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indictors is provided in the table. It is important to note that whilst these indicators must be included in the Quality Accounts the more recent national data available for the reporting period is not always for the most recent financial year. Where this is the case the time period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

The information in the table is followed by explanatory narrative for all indicators, ordered by outcome domain.

Summary table of performance against mandatory indicators

Outcome Domain	Indicator	Most recent data	National Average	Best	Worse	last report period	last report period	last report period
Preventing people from dying pre-maturely	SHMI Reporting Period:	Oct16 -Sept17				(Oct 15 – Sept 16)	(Jul 15 – Jun16)	(Apr 15 – Mar 16)
	Summary Hospital-Level Mortality Indicator (SHMI) value and banding	100.81 Band 2 = As expected	100	NA	NA	108 Band2 = As expected	112 Band 1 = higher than expected	113 Band 1 = higher than expected
	The percentage of patient deaths with palliative care coded at either diagnosis or Specialty level for the Trust for the reporting period.	30%	29.6%	NA	NA	27.9%	25.2%	22.2%
Helping people recover from episodes of ill health or following injury	18. PROMS; Patient Reported Outcome Measures Reporting Period:	(2016/17)				(2015/16)	(2014/15)	(2013/14)
	(i) hip replacement surgery,	0.44	0.44	N/A	N/A	0.45	0.45	0.44
	(ii) Groin Hernia	0.07	0.09	N/A	N/A	0.07	0.08	0.07
	(iii) Varicose Veins	0.12	0.09	N/A	N/A	0.12	0.12	0.11
	(iv) knee replacement surgery.	0.32	0.32	N/A	N/A	0.32	0.33	0.34
	19. Patients readmitted to a hospital within 28 days of being discharged. Reporting Period:	Apr17-Feb18				(2016/17)	(2015/16)	(2014/15)
	(i) 0 to 15; and	10.3%	Not released by NHS Digital			10.32%	11.43%	10.64%
	(ii) 16 or over.	11.1%				8.96%%	11.95%	10.80%

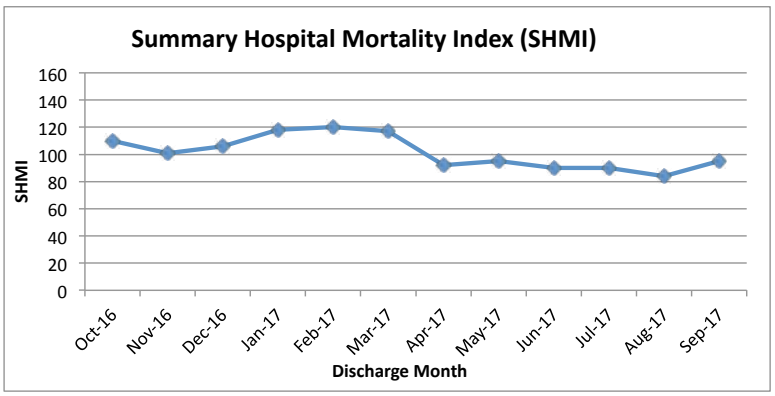
Outcome Domain	Indicator	Most recent data	National Average	Best	Worse	last report period	last report period	last report period
Ensuring that people have a positive experience of care	National Survey Reporting Period:	2016				2015	2014	2013
	20. Responsiveness to the personal needs of patients.	6.8	N/A	N/A	N/A	7.1	7.1	6.9
	Reporting Period:					2016	2015	2014
	21. Staff who would recommend the Trust to their family or friends.	3.63	3.76	NA	NA	3.72	3.67	3.68
Treating and caring for people in a safe environment and protecting them from avoidable harm	Reporting Period:	Apr17–Mar 18				2016/17	2015/16	2014/15
	23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	94.39%	N/A	N/A	N/A	95.11%	95.4%	95.3%
	C.difficile Reporting Period:	Apr 16 – Mar 17				15/16	14/15	13/14
	24. Rate of C.difficile per 100,000 bed days	12.7	13	0	147	10.4	11.4	6.2
	Patient Safety Incidents - Reporting Period:	Oct 16 - Mar 17				April 16 - Sept 16	Oct 15 – Mar 16	Apr 15-Sept 15
	(i) Rate of Patient Safety incidents per 1000 Bed Days	39.6	40.5	N/A	N/A	41.2	40.1	37.5
	(ii) % of Above Patient Safety Incidents = Severe/Death	0.3	0.14	N/A	N/A	0.21	0.1	0.7

Domain: Preventing people from dying prematurely

The Summary Hospital Mortality Index (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with the predicted number of deaths. Each hospital is placed into a band based upon their SHMI, the Trust is currently in the 'expected range' category.

There is a six month time lag in the availability of data for this indicator. SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI.

Measures of mortality namely Hospital Standardised Mortality Rate, HSMR and SHMI have consistently improved over the past few years. In April 2016 the Trust HSMR was 113.9 and SHMI was 116.8. This improvement is undoubtedly multi-factorial and is a result of a number of Quality Improvement (QI) Initiatives that includes the use of digital technology.



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

EPR was implemented in May 2017 and the Trust had maintained an improving HSMR and SHMI since then. EPR benefits include integration of Nervecentre and EPR, ease of visibility of the medical record especially when a patient deteriorates, improved do not attempt cardio pulmonary resuscitation (DNA-CPR) documentation, universal sepsis screening, e-prescribing and medicines administration. There are ongoing plans to further optimise the use of EPR in QI for example use of ward level dashboards and safety huddles. The Trust has established a monthly Mortality Surveillance Group reporting to the Quality Committee through the Clinical Outcomes Group.

During 2017/18 The Trust continued its work around mortality case note review.
The Trust has performed both initial screening reviews and more in depth structured judgement reviews for a number of years. The revised Learning from Deaths (LfD) policy was published on both the intra and internets in September 2017. Learning from this has highlighted areas for improvement as below:

Theme	QI Response	Result
Delay/lack of medical review	Included in the 7 day working and hospital @ night (HOOP) – Deteriorating Patient work-stream	Fully compliant with 7-day standard 2 HOOP fully imbedded Deterioration Programme continuing to focus on Recognition, Response and Prevention of deterioration in patients
Delayed medications, mainly antibiotics	Included in the Medication Safety Group and Sepsis work-stream	EPR in place for closer surveillance of medication administration Sepsis collaborative QI
Observations not performed as policy	Implementation of Nervecentre for electronic observations and escalation	Marked improvement since Nervecentre was introduced. Ongoing optimisation QI work on accuracy of observations and response to escalations through the Deterioration Programme
Delay or lack of escalation of NEWS		
Incomplete bundles	Review of bundles	Sepsis screening through EPR and ongoing QI with sepsis COPD and pneumonia QI through national audits AKI collaborative reformed
Fluid balance recording	Introduction of EPR	Ongoing optimisation of fluid balance recording

Learning from Death was the subject of the 'Sharing Learning - Improving Care' newsletter and was published in August 2017. This was distributed across the Trust with the intention to share learning from the mortality reviews with frontline staff. The newsletter describes the journey of improvement (see below).

SHARING LEARNING – IMPROVING CARE

ISSUE 2: AUGUST 2017

SHARING LEARNING IMPROVING CARE

SHARING LEARNING IMPROVING CARE

NHS Calderdale and Huddersfield NHS Foundation Trust

ISSUE 2: AUGUST 2017

Mortality: talking points

SHARING LEARNING – IMPROVING CARE

Why do we measure mortality?

Measures of mortality are one of the indicators which could signal concerns with care provided by hospitals. They provide information on expected deaths both in and out of hospital and measure if a hospital trust is seeing on average, higher or lower than average number of deaths than expected among patients. Mortality rates are benchmarked nationally for all trusts using a range of tools such as HSMR (Hospital Standardised Mortality Ratio) and SHMI (Summary Hospital-level Mortality Indicator).

How standardised mortality rates are calculated

- Firstly a benchmark of 100 has been calculated based on mortality rates for all acute hospitals in England and Wales.
- The year is compared on the number of actual deaths against the number of predicted deaths for the patients treated at CHFT.
- A ratio of 100 means expected number of deaths matched actual number of deaths. Above 100 means we had more than expected, less than 100 means we had less than expected.
- SHMI rates include in-patient deaths and deaths that occur within 30 days of discharge.

What have we learnt from our death reviews?

Common factors identified following investigation into deaths. Things that haven't always happened:

- Recording of patients observations and escalation when scores are raised
- Accurate fluid balance charts in sick patients
- Daily senior review, particularly at weekends
- Drugs given on time
- Sepsis screening when raised NEWS score
- Timely discussions with patients, families and carers where death is inevitable

Questions to ask yourself / your team:

- Are we performing patients observations at the recommended times?
- Are we clear about the need to escalate raised NEWS?
- Are we doing sepsis screen on patients with a NEWS 3 or more?
- Are we speaking to patients, families and carers at the earliest opportunity when death is inevitable?
- Are we considering why patients have an imbalanced fluid balance and what action to take?
- Is your documentation specific Complete Accurate Relevant (CCAR)?

How well are we doing?

SHMI - Data for rolling 12 month SHMI until September 2016 – **108.05** (categorised as Band 2 – as expected). This is an improved position from 112.0 from the same period last year.

HSMR - The 12 month rolling data up to March 2017 gives a HSMR score a **100.87** (categorised "as expected"). This is an improved position from 111.01 from the same period last year.

If you think "Someone should do something", remember, you are someone and you can do something!

Focus on Learning from Death

Feedback from colleagues is that we don't always share the outcomes from investigations, including what was learnt and what should be done differently. To learn when something goes wrong we need to know:

- **What happened?**
- **Why it happened?**
- **What can be done to prevent it happening again?**

This document provides facts and learning from our investigations following death, such as information from mortality reviews, complaints investigations, an incident investigation or an inquest.

hello my name is... Carole Hallam

For many patients, death is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision.

The purpose of reviews and investigations of deaths, in which problems in care may have contributed to, is to learn in order prevent recurrence.

Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon (NHS England 2017).

" I am the Senior Nurse for Clinical Governance.

I want to share more information about why having a focus on learning from death is a priority for our Trust "

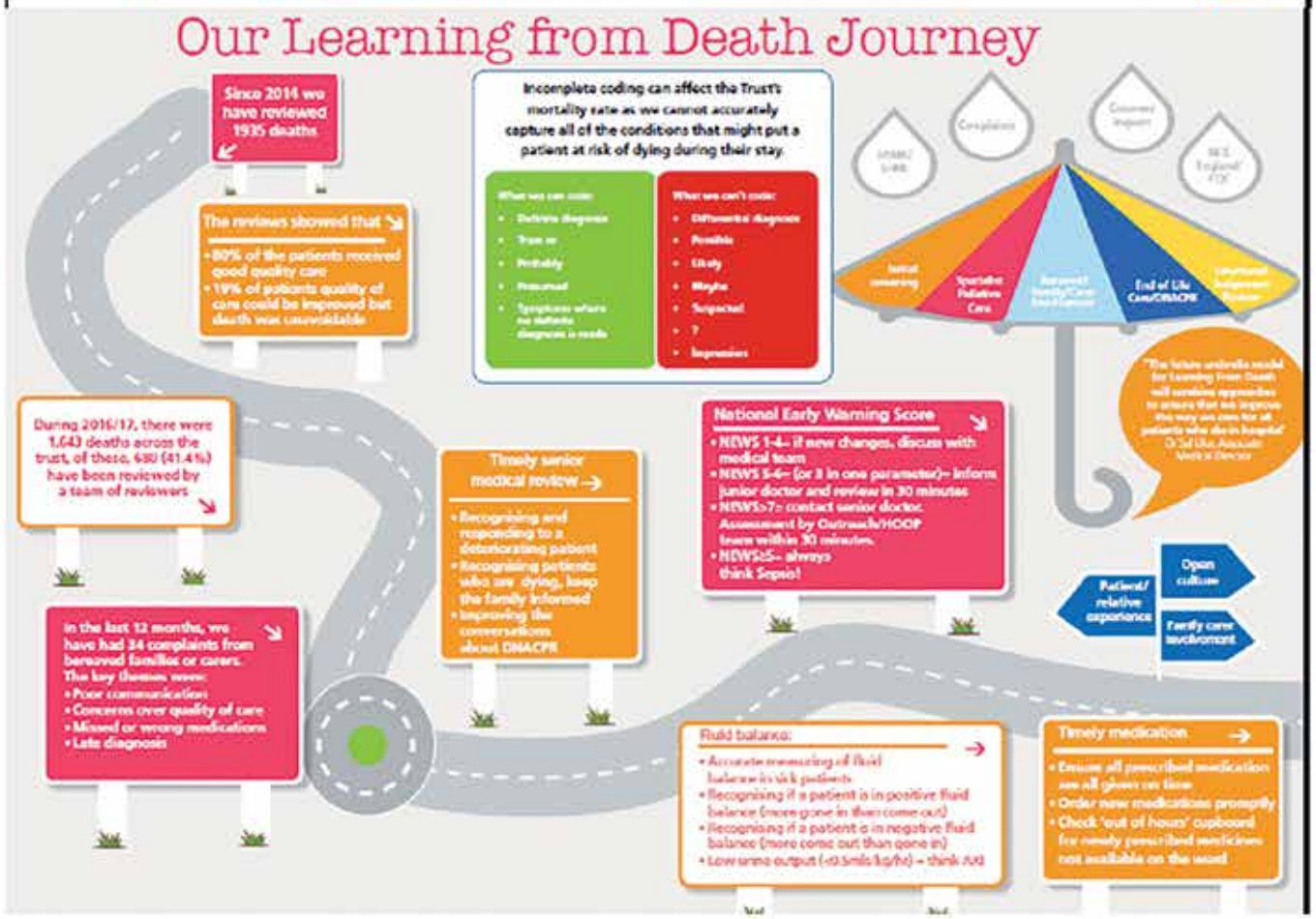
Read on to find out what we know about mortality here at CHFT, including:

1. What we have learnt about Mortality as a Trust
2. What we can do to improve the quality of care for our patients
3. How mortality rates are calculated

The Governance and Risk Team will be publishing regular themed reports to encourage learning from our adverse events. If there is a topic you would like us to feature, please contact Laura Malik (Directorate Secretary) on behalf of the editorial panel.

compassionate care

Our Learning from Death Journey



As a Trust we recognise the significant improvements in HSMR and SHMI as measures of mortality. The emphasis will continue to be learning from deaths through the new LfD structure and process. In addition the new LfD Umbrella will align QI strategies including morality reviews and EOL to promote wider learning to improve patient care. The Deterioration Programme will continue to drive improvements in the recognition and response to patients who become unwell. Safety huddles will remain the chosen method by which safety cultures are driven at a ward level. Finally the Trust is committed to the use of digital technology including the EPR as a significant enabler for QI.

Domain: Helping people recover from episodes of ill health or following injury
Patient reported outcome measures (PROMs)

A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery, patients are asked to score their health before and after surgery. We are then able to understand whether a patient sees a 'health gain' following surgery.

The data provided gives the average difference between the first score (pre-surgery) and the second score (post-surgery) that patients give themselves. In November 2017 NHS England discontinued the mandatory varicose vein surgery and groin-hernia surgery, however these are included in the PROMs table above and charts 4a and 4b below.

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

Participation rate across both procedures, for CHFT was 90.1%, which is in line with the national average of 90.5%

(i) Hip replacement surgery,

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Calderdale	0.45	0.43	0.44	0.49	0.44	0.45	0.45	0.44
National	0.42	0.44	0.44	0.44	0.41	0.43	0.44	0.44

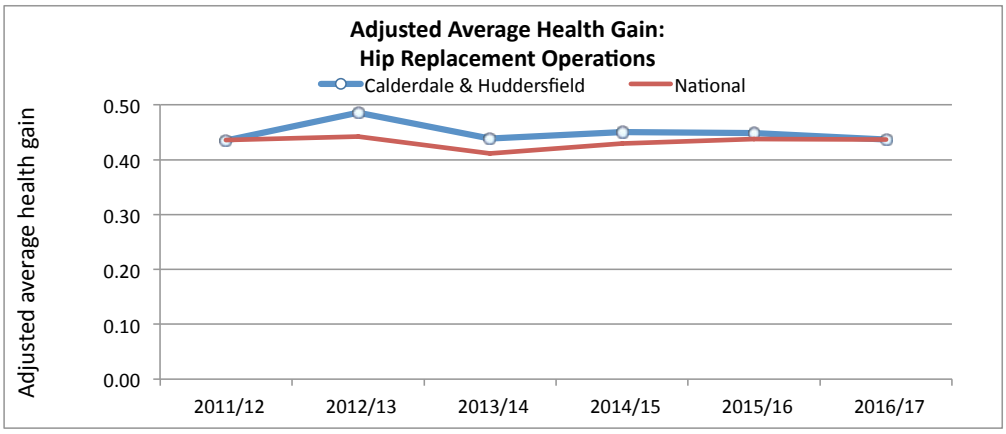


Chart 4: PROMS – Hips

(ii) Groin Hernia

	2012/13	2013/14	2014/15	2015/16	16/17
Calderdale & Huddersfield	0.07	0.09	0.08	0.07	0.07
National	0.09	0.08	0.08	0.09	0.09

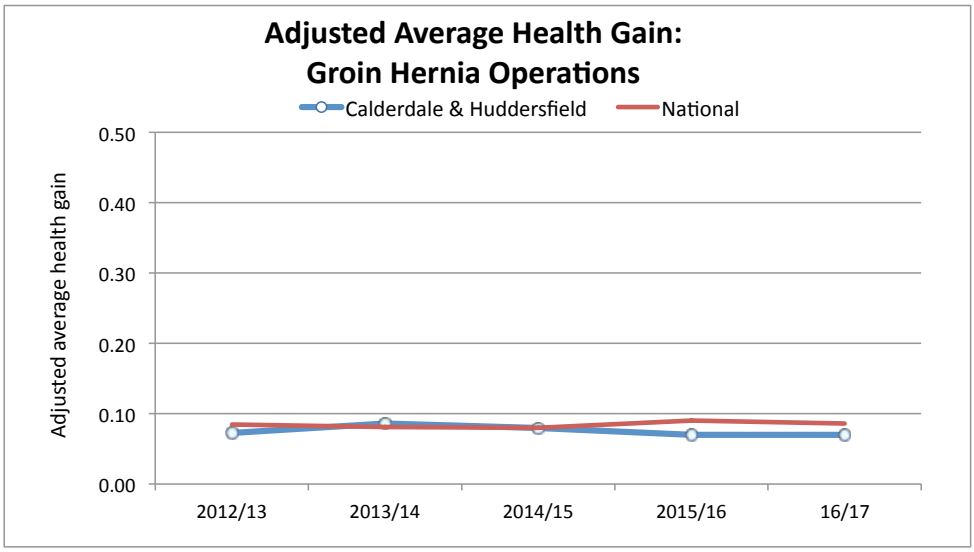


Chart 4a: PROMS – Groin Hernia

(iii) Varicose Vein

	2012/13	2013/14	2014/15	2015/16	16/17
Calderdale & Huddersfield	0.11	0.11	0.12	0.12	0.12
National	0.09	0.10	0.09	0.10	0.09

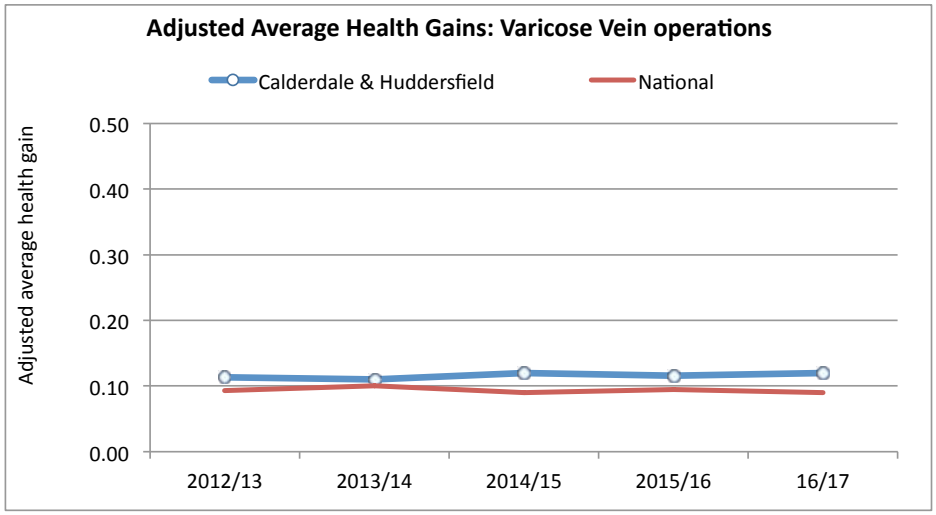


Chart 4b: PROMS – Varicose Veins

EQ-5D

(iv) Knee replacement surgery.

	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Calderdale	0.33	0.38	0.32	0.37	0.34	0.33	0.33	0.32
National	0.30	0.30	0.30	0.32	0.32	0.31	0.32	0.32

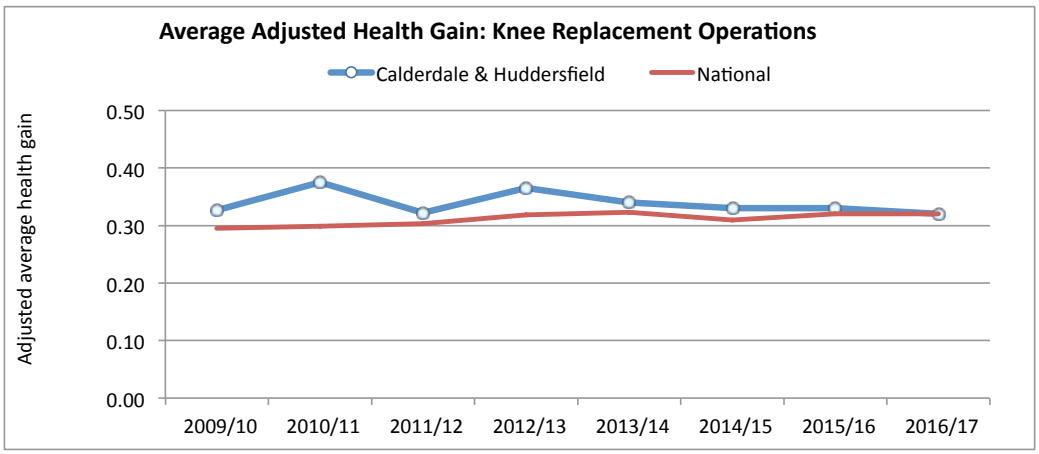


Chart 5: PROMS - Knees

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

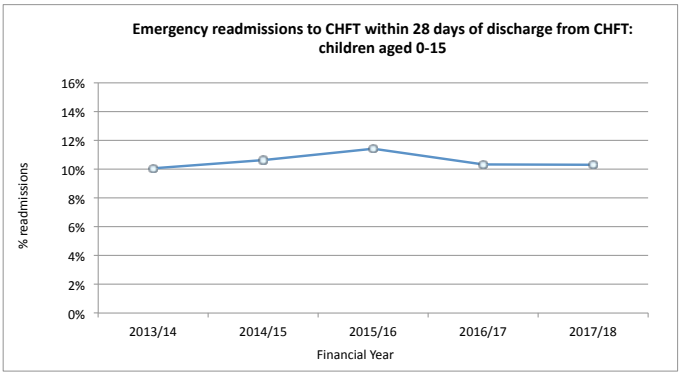
Continuing to ensure this data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice.

READMISSIONS WITHIN 28 DAYS

The charts show the percentage of patients readmitted within 28 days of discharges, aged:

1. 0 to 15; and
2. 16 and over;

	2013/14	2014/15	2015/16	2016/17	2017/18
0-15	10.06%	10.64%	11.43%	10.32%	10.30%
16+	11.26%	10.80%	11.95%	8.96%	11.10%



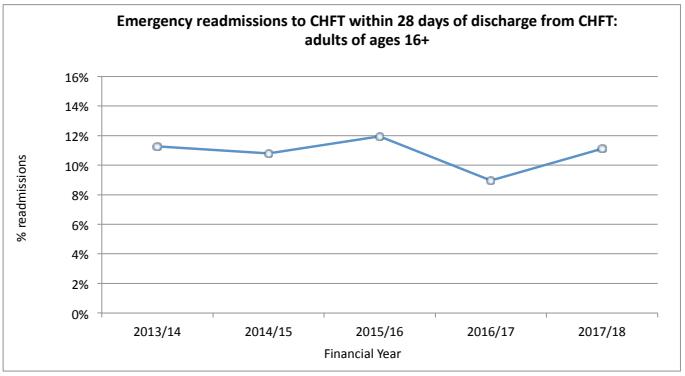


Chart 6: Readmissions within 28 days of discharge

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

- At present there is no national 28 day readmission rate available. The data is not due to be released by NHS Digital until a methodological review takes place.
- Following the implementation of the Electronic Patient Record (EPR) this indicator needed to be reviewed in order to make sense of the new pathways that were available. As such the previous year's performance has also been adapted to reflect the new approach to this measure.
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

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

- Through better planned discharges which will lead to fewer readmissions
- Implementation of Safe and Effective Patient Flow Programmes, (see 2018/19 priority two in section two)

Responsiveness to the personal needs of patients (Question 20).
The national indicator is a composite of the following questions and calculated as the average of five survey questions from the National Inpatient Survey.

Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs" (based on the 2016 survey).

- *Q35: Were you involved as much as you wanted to be in decisions about your care and treatment?*
- *Q38: Did you find someone on the hospital staff to talk to about your worries and fears?*
- *Q40: Were you given enough privacy when discussing your condition or treatment?*
- *Q63: Did a member of staff tell you about medication side effects to watch for when you went home?*
- *Q69: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*

20. Responsiveness to the personal needs of patients.	2012	2013	2014	2015	2016
	7.0	6.9	7.1	7.1	6.8

Calderdale and Huddersfield NHS Foundation Trust consider that this data is as described for the following reason:
The National Inpatient Survey was sent to 1250 patients who had been discharged from inpatient wards at Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH) in July 2016. People were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Overall, we had 555 patients who returned completed questionnaires giving a response rate of 47%. This has dropped slightly compared to previous surveys, see the table below:

% of Responses for National Inpatient Survey	2012	2013	2014	2015	2016
	50%	51%	49%	44%	47%

Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve this score and the quality of its services by continuing to use patient feedback to create improvement plans for both the overall Trust and individual areas.

Staff Experience

Staff who would recommend the Trust to their family or friends (Question 21)

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

The Trust carried out a census survey in 2017. A total of 2434 colleagues completed and returned the survey to the Picker Institute Europe, our survey co-ordinator. Our response rate was 43% (45% in 2016).

The majority of our scores remained unchanged from 2016. Our best performance areas are:
- Percentage of staff appraised in last 12 months
- Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff experiencing discrimination at work in the last 12 months
- Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months

Our worst performance areas are:
- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves
- Percentage of staff feeling unwell due to work related stress in the last 12 months
- Organisation and management interest in and action on health and wellbeing
- Quality of appraisals
- Effective use of patient / service user feedback

The staff survey score for indicator KF1 with contributing questions:

Question/ Indicator	CHFT 2017	CHFT 2016	National Average
KF1 - Staff recommendation of the Trust as a place to work or receive treatment	3.63	3.72	3.76
Q21a Care of patients/service user is my organisations top priority	70	77	76
Q21c I would recommend my organisation as a place to work	54	59	61
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	66	68	71

Looking at the survey as a whole the following table below shows where the Trust performed in the best 20%, better than average, worse than average or worst 20% than the national average.

The responses to KF21, KF25, KF26 and Q17b are reported for the Workforce Race Equality Standard

Question/ Indicator	CHFT 2017	CHFT 2016	National Average
KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White - 28% BAME – 21%	White - 28% BAME – 14%	White - 27% BAME – 28%
KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White – 23% BAME – 25%	White – 24% BAME – 23%	White – 25% BAME - 27%
KF21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	White – 88% BAME – 68%	White – 88% BAME – 76%	White – 87% BAME – 75%
Q17b In the 12 last months have you personally experienced discrimination at work from manager/team leader or other colleagues?	White – 5% BAME – 20%	White – 5% BAME – 14%	White – 7% BAME – 15%

3.3. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

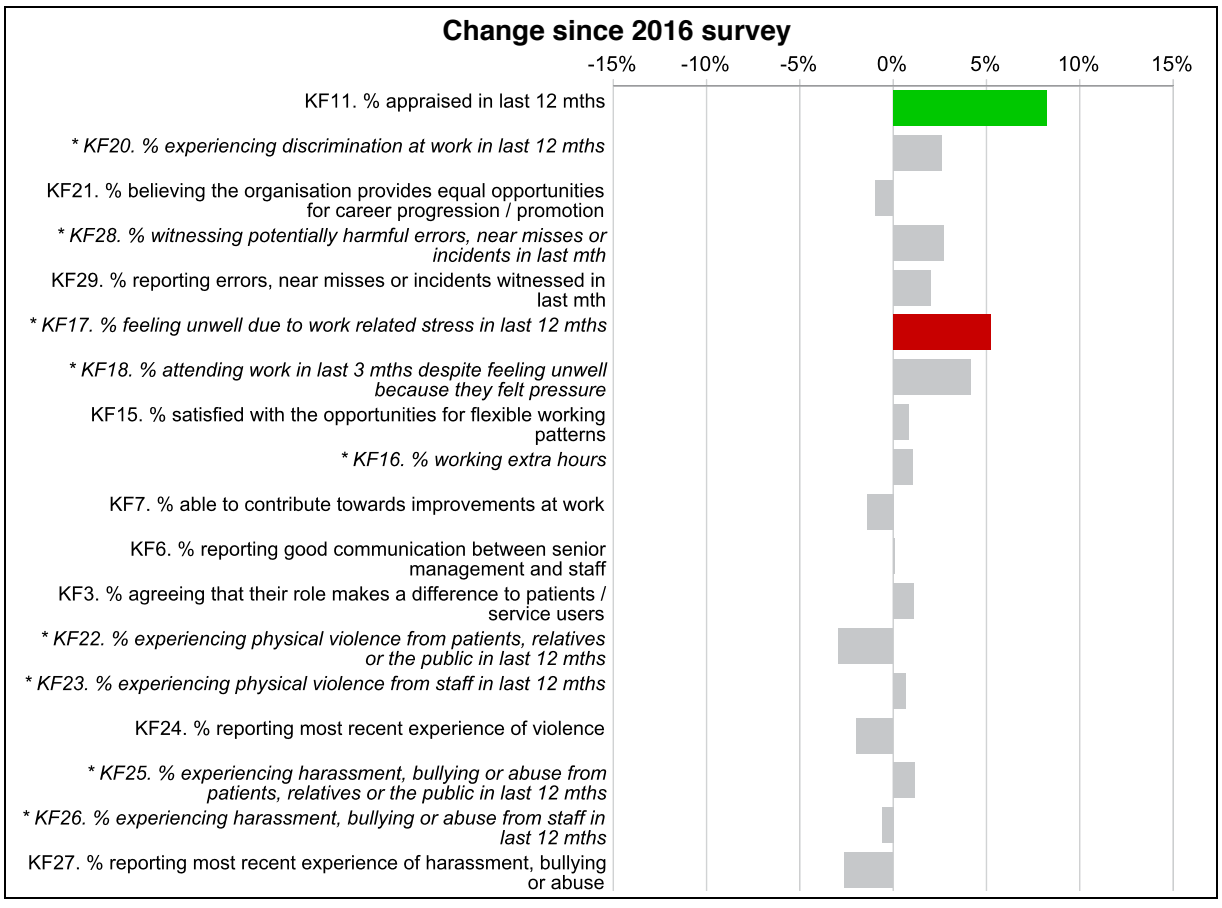
KEY

Green = Positive finding, e.g. there has been a statistically significant positive change in the Key Finding since the 2016 survey.

Red = Negative finding, e.g. there has been a statistically significant negative change in the Key Finding since the 2016 survey.

Grey = No change, e.g. there has been no statistically significant change in this Key Finding since the 2016 survey.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



Calderdale and Huddersfield NHS Foundation Trust has implemented the Workforce Strategy which has at its core four behaviours that the Trust expects to see across the organisation. The Trust continues to work to embed these key values through its Working Together, Get Results programme.

The behaviours are:

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

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients admitted to hospitals that were risk assessed for venous thromboembolism.

Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE. The chart shows the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from April 2017 to February 2018. The target from December 2012 for VTE risk assessment for all patients admitted was set at 95%

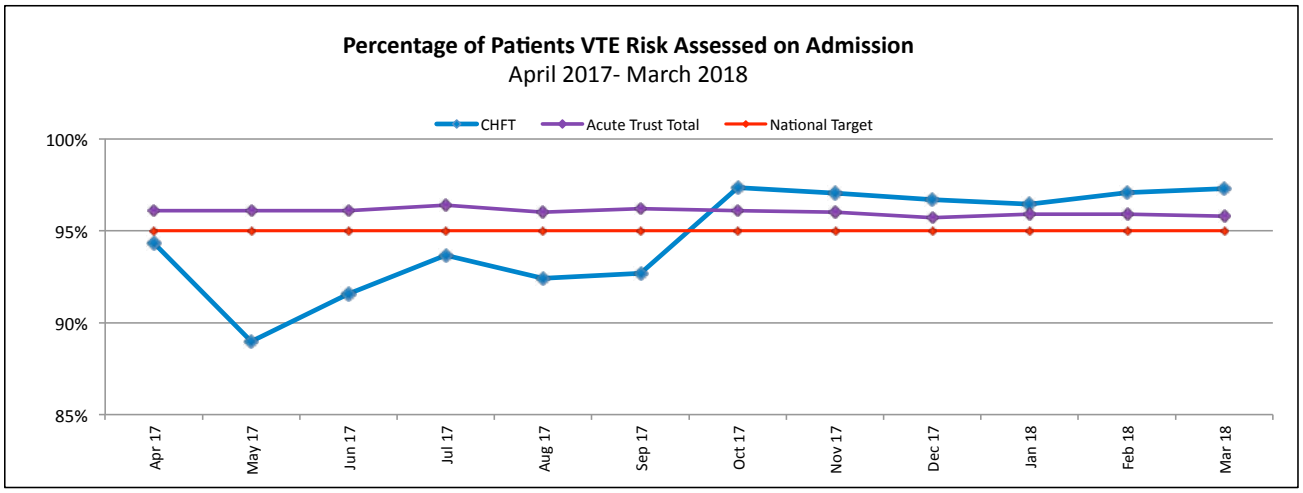


Chart 7: % VTE Risk Assessment Completed

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

Compliance data is now retrieved through our Electronic Patient Record (EPR) when the patient has been discharged from hospital and coded.

In the months after the Trust went live with the new EPR system we witnessed a slight drop in performance, which dipped below the 95% target, (as can be seen on the graph above). Following this an extensive deep dive into the areas and patients being cohorted within the data was started, with the help and guidance of the clinical lead for VTE. The cohort arrangements being used had not been reviewed in most cases since 2011, therefore a redesign was required to reflect changes within the Trust in that time.

The new cohorting system that has been designed and signed off for use by the Medical Director now uses a method of looking at the procedure code for the spell, along with taking into account the LOS of the spell.

This involved identifying low risk procedures, and looking at patients with a LOS of less than 24 hours and identifying them as having a low risk of VTE. In doing this it was felt that this was a much more accurate measure of Trust performance around VTE assessments.

This cohorting is carried out for reporting purposes only and does not mean that a VTE assessment is not required for patients that fall within these cohorts.

The benchmarking graph shows the Trust to be in the bottom third of Trusts for Q2 2017/18 data, however as can be seen from the first graph, this position as been improved significantly in Quarter 3 of 2017/18.

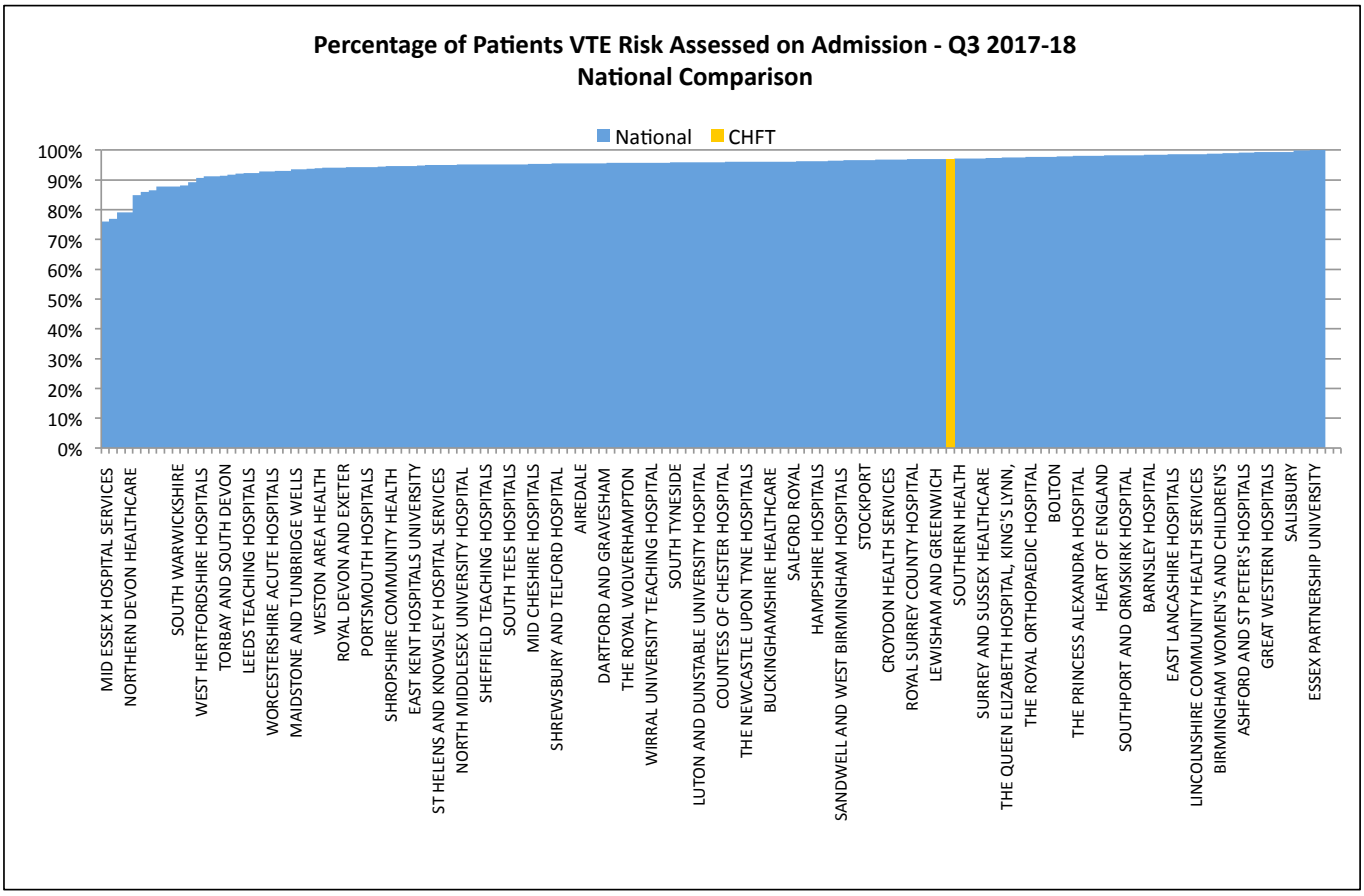


Chart 8: % VTE Risk Assessment Benchmarking

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

- Undertaking work to improve reliability of data and patient care, with work underway to have the VTE assessment incorporated in the new EPR for doctors to complete. This will allow data on compliance with the process to be reviewed live so any issues can be addressed immediately. In addition to this the system will include a prompt the doctors to review the VTE assessment after 24 hours.
- Ensuring there is a reliable process so that when hospital associated VTE's are identified they are investigated for any failings of care and actions taken wherever necessary.

Rate of C.difficile per 100,000 bed days (2017/18)

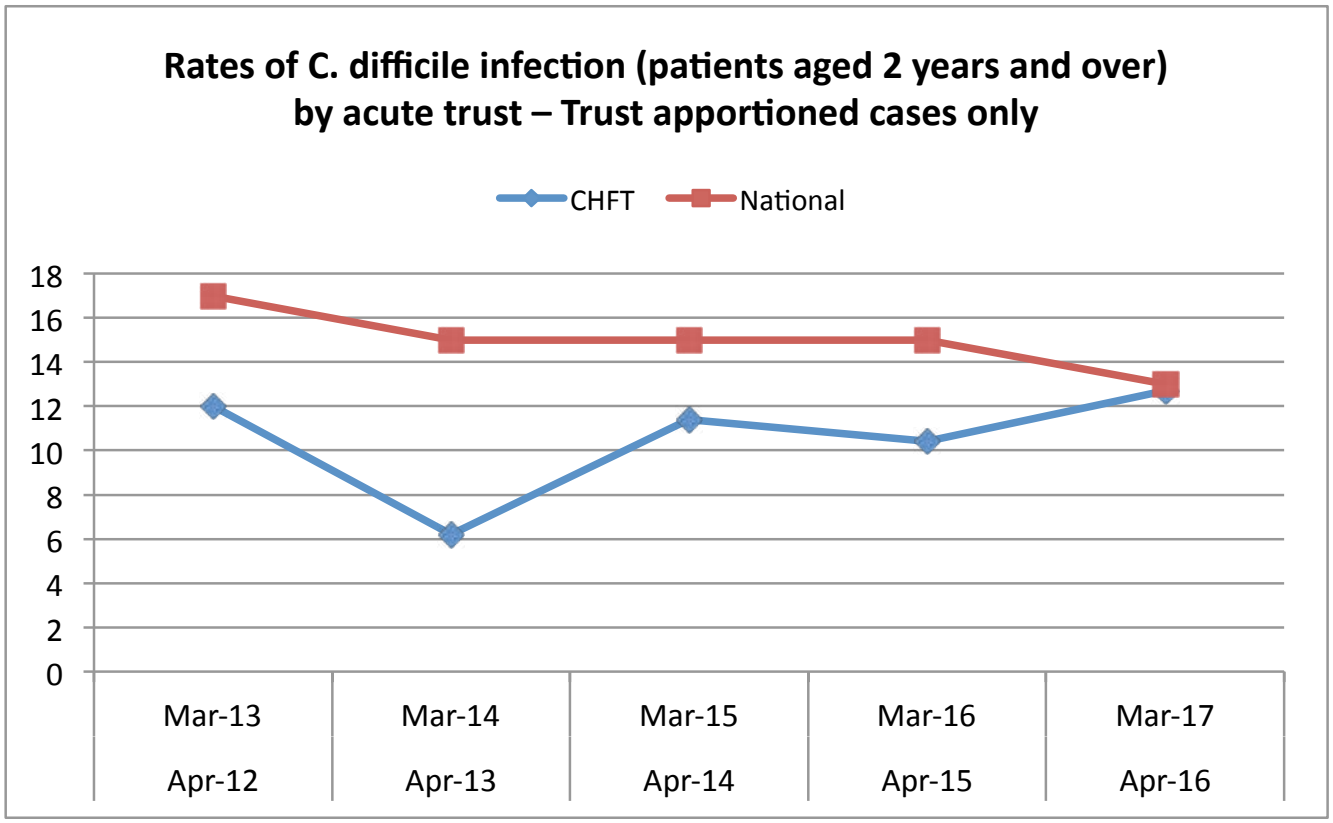


Chart 9: C.Diff Trust apportioned cases

2017/18 has continued to be a challenging year with respect to our absolute numbers of Clostridium difficile infections (CDI), specifically in relation to our performance versus our target.

Whilst we continue to report rates of infection below the national average as indicated in the chart above we have seen a narrowing of the gap.

Of 153 reporting Trusts, Calderdale and Huddersfield NHS Foundation Trust is 61st.

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

At the time of writing the Trust has exceeded our ceiling of cases of CDI by 16 cases (ceiling 21, current position 37 cases). All cases are subject to a root cause analysis which is externally supported, and scrutinised, by our commissioners. In the vast majority of cases, we have been unable to identify specific lapses of care that have directly led to the CDI – the quality of the care provided has been found to be good.

However, in eight cases, we have been able to identify key areas for improvement. These relate to antimicrobial use prescribing, environmental cleaning and hand hygiene. All root cause analyses conclude with an action plan to ensure that lessons learnt are acted upon, and that learning is disseminated throughout the organisation to try to prevent similar, avoidable cases. Action plan completion is monitored through the divisions.

The Infection Prevention and Control Team support prevention of C. difficile through the delivery of both mandatory training, and bespoke sessions to clinical areas. An annual hand hygiene roadshow is held which has shown good, rising levels of compliance with bare below the elbows and hand hygiene. Additionally we continue to work with clinical teams and microbiology to improve antimicrobial prescribing through the use of antimicrobial stewardship ward rounds, and with Estates and Facilities to maintain, and improve where necessary, standards of cleaning.

Serious Incidents

(i) Rate of Patient Safety incidents per 1000 Bed Days

Patient safety incidences

The chart above shows the Trust's previous reporting on the National Reporting and Learning Service. Patient safety incidents, reported to the National Reporting and Learning Service, make up 84% of all reported incidents in CHFT. The national levels of reporting continue to rise, but the Trust had seen a reduction in overall reporting. Internal figures indicate that this trend started to reverse, with reported number of incidents increasing in October/ November 2017, and will be reflected in the figures for 2018/19.

The Trust is committed to learning from incidents at all levels, and looks at the prevalence of incidents by theme, producing learning newsletters and "bite-sized" learning to focus attention on identified gaps. The Trust will continue to look at how we can better share and embed learning with all staff to reduce the risk of harm across the organisation.

Serious Incidents

The Trust is committed to improve patient safety by identifying, reporting and investigating serious incidents (SIs), ensuring that actions are taken to reduce incidents reoccurring and that learning is shared across the organisation.

Weekly Executive led panels assess potential serious and severe harm incidents that may meet the reporting criteria. Decisions are collectively made with regard to grading of incidents, duty of candour leads and allocation of investigators.

All serious incidents are reported to commissioners and, as part of the Trust's commitment to openness and honesty, the patient or their relatives receive an apology and are invited to meet to contribute questions to the investigation. A root cause analysis investigation (RCA) is undertaken for each serious incident, producing a report and action plan which is shared with the patient and / or their relatives. Each report is reviewed at the Executive-led serious incident panel to ensure it addresses the root cause of the incident and identifies appropriate actions.

Once approved reports are submitted to the commissioners managers follow up monitoring of the actions arising from the investigation and assurance on this is presented to the Divisional Patient Safety Quality Board.

A Serious Incident Review Group met four times during the year, chaired by the Chief Executive, with membership including senior clinical divisional colleagues. The group provides assurance that the Trust is managing Serious Incidents effectively, identifying themes, and seeks assurance that learning from SIs is shared across the organisation. The group reports to the Quality Committee.

The Quality Committee receives information on new serious incidents, and recommendations and actions being taken to reduce risk. In 2017/18, the Quality Committee also received an assurance report on progress across the Trust with implementation of actions arising from serious incidents.

Themes and trends: The three most frequently reported serious incidents in 2017/18 were:

Incident Type	Number in 2017/18	Comment
Falls with harm	16 incidents	A Falls Collaborative is working on improvements supported by the Improvement Academy.
Pressure Ulcers	5 incidents	There is a new Pressure Ulcer investigation tool to help better understand why pressure ulcers arise.
Infection	5 incidents,	This represents 4 serious incidents, as two incidents were investigated as one due to apparent transmission from one to the other. In 2017/18 there has been a review of the hand hygiene audit process, to strengthen this, a peer review of the weekly environment audits, a revision of the audit and a deep clean of Huddersfield Royal Infirmary undertaken.

Investigations into these incidents enable us to identify and undertake preventative work to improve patient safety.

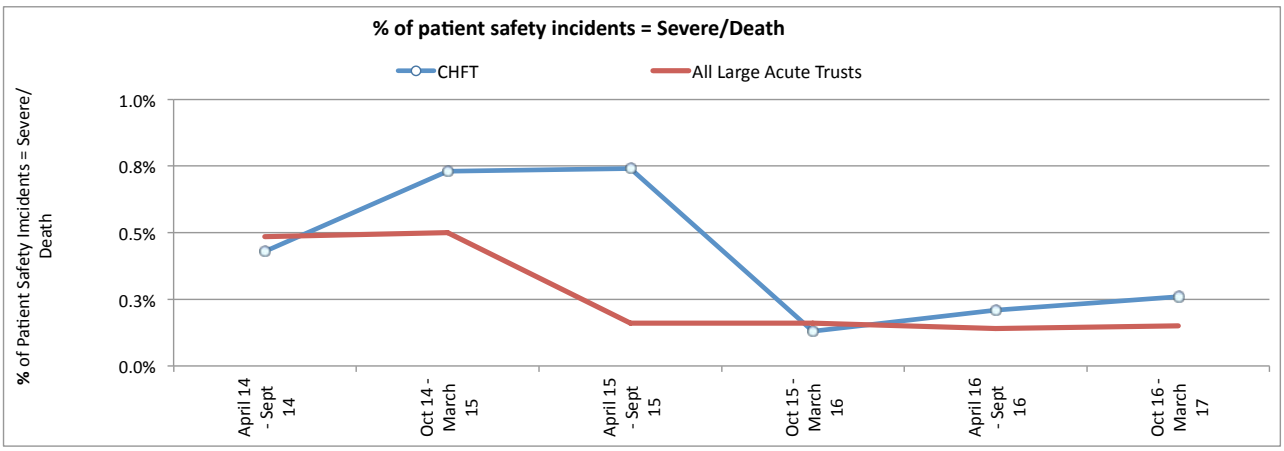
Never Events

A never event is a specific serious incident that NHS England has determined is preventable and should not happen if national safety guidelines are followed.

Over 2017/18 the Trust has reported one never event. This was a wrong site surgery, where the wrong ureter was stented initially, but the error recognised and the correct ureter stented while the patient was still in theatre. No harm was sustained by the patient as a result of this error.

(ii) % of Patient Safety Incidents graded as Severe/Death

The following chart shows the % of incidents graded as severe harm or death.



The chart demonstrates an increase in incidents of severe harm or death in relation to other organisations to March 2017.

There has been an indication in 2017/18 of a reduction in the most severe harm incidents, while an increase in orange, or moderate harm. This reflects the approach to score incidents initially as orange and investigate, reassessing the actual harm following the investigation.

Patient Incidents by Severity

CHFT Incidents	2015/16	2016/17	2017/18	movement
Green	6467	6337	6677	↑ 5%
Yellow	1955	1478	1354	↓ 8%
Orange	130	165	211	↑21%
Red	44	74	59	↓21%
Totals	8596	8054	8297	↑ 3%

Green / Yellow Incidents (No / low harm)
There has been an increase in incident reporting in 2017/18 in comparison to 2016/17, reflecting an improvement in incident reporting from October / November 2017 onwards. High levels of incident reporting are a positive indicator of a safety culture; in Calderdale and Huddersfield NHS Foundation Trust, over 95% of the incidents reported were zero or low harm. Work has started to help staff to explore and understand the range of incidents which should be reported, so we can better address risks to patient safety from low level harm incidents.

Orange incidents (moderate harm)
Throughout the Trust, weekly incident panels for those incidents that have caused moderate harm have continued to take place at a divisional level, ensuring a robust process for assessing incidents, reviewing completed investigation reports and ensuring effective communication with those affected by the incident, known as duty of candour is completed in a timely manner. The increase of orange incidents shows that more divisional investigations are taking place to improve patient safety and support staff in learning from incidents.

Red incidents (serious incidents)
In 2017/18 59 incidents were severity rated as "red – serious" and reported to the Clinical Commissioning Group as per the requirements of the National Serious Incident Framework. Not all of these were incidents resulting in severe harm or death, for example, a 12 hour breach resulted in no physical harm, and the investigation recognised excellent adherence in the Emergency Department to patient dignity and provision of food and fluids throughout. A review of the conclusions in the serious incident reports indicates that serious harm was evident from the incident in approximately half of the cases. A further two cases were rated as orange but investigated at red. The advantage in reporting an incident as red ensures a high level root cause analysis investigation, with an investigator independent to the service where the incident occurred. The investigation is then subject to robust scrutiny.

Duty of Candour
All Trusts are required to comply with the statutory duty of candour after becoming aware of an incident which has caused harm classed as moderate, severe or death on the National Reporting and Learning Systems (NRLS).

Performance is monitored on duty of candour with information reported monthly to the Trust Board on the provision of an initial letter of apology. We also monitor performance on sending a further letter of apology with a copy of the investigation report through the monthly Patient Safety Group.

The patient or relatives involved in a serious incident are invited to contribute questions to the investigation, and once a report is completed patients and relatives are routinely offered a meeting with staff to discuss the report, unless they have previously indicated that they do not wish to meet.

The Trust is continuing to work towards further improvements in the duty of candour process, to ensure we are supporting patients and families involved in significant events better. Work has commenced to introduce further support to those patients or families who have been distressed by an incident of moderate or greater harm.

Part 3: Performance on selected quality indicators

This section provides an overview of care offered by the Trust based on its performance in 2017/18 against a number of regularly monitored quality indicators. These are selected by the Trust Board in consultation with stakeholders and reviewed regularly.

The indicators are as follows:

Domains	Indicator
Patient Safety	Mortality Rates (HSMR and SHMI)
	Falls in Hospital
	Healthcare Associated Infections
Clinical Effectiveness	Cancer Waiting Times
	Stroke
	Safe and Effective Care (previously LoS Medicine)
Patient Experience	End of Life care
	Patient Experience Inc Friends and Family Test
	Complaints
Staff Experience	National Survey
	Friends and Family Test

Hospital Standardised Mortality Rate (HSMR)

Through understanding our hospital mortality the Trust is able to both gain assurance and learning regarding current care processes and further identify any areas requiring improvements.

There are two main standardised measures. These ratios examine the number of patients who die, either during or, following hospitalisation at the Trust by looking at the expected number of cases in an average English hospital, given the characteristics of the patients treated there.

1. The SHMI calculated by NHS Digital looks at patients who had died either in hospital or within 30 days of discharge.
2. The HSMR is a long standing national measure which only looks at those patients who die during their hospital stay.

Our most recent HSMR is shown below (accessed 14/04/18)

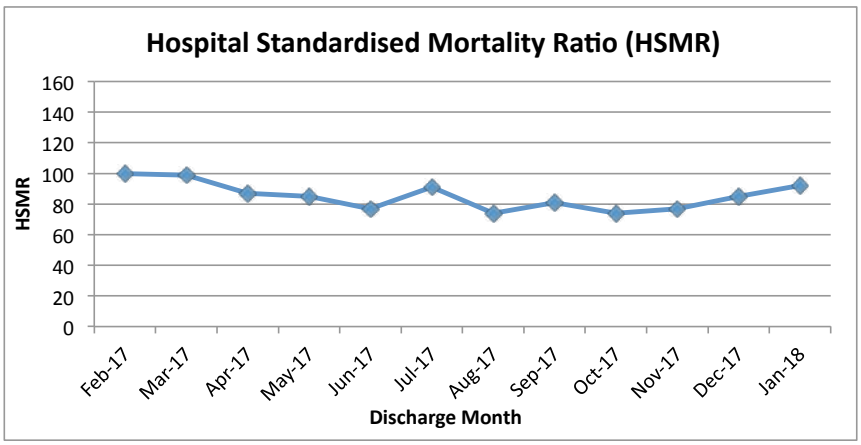


Chart 12: HSMR

See Part 2 for a look into our SHMI performance and work on the Mortality Case Note Review programme. (page 20)

Falls in Hospital

Falls in hospitals are the most common patient safety incidents reported in hospitals in England. Falls not only impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality, they are estimated to cost the NHS more than £ 2.3 billion per year.

The fall improvement collaborative has continued in 2017/18 with a monthly falls dashboard has been introduced to provide an overview of falls incidents and key themes to share learning to heighten awareness on preventative actions to reduce falls. Most wards now have a "days between falls "board to support improvement work and several success stories of 40 days plus between falls. An internal 'falls prevention gets attention' campaign was launched to brand this work and an awareness day in May 2017 resulted in increased awareness across the Trust.

There has been ongoing work to devise safety huddles across medical wards –these are being supported to provide a multidisciplinary focus on falls assessment and preventative intervention. There is evidence from the medical assessment unit (MAU) at Calderdale Royal Hospital (CRH) that three times daily huddles and targeted work on intentional rounding has reduced falls .The leadership and involvement from the clinicians have played a valuable part in this work.

There is ongoing emphasis on falls monitor training monitored monthly via medical device training. Post falls investigations have shown that a falls monitor is not appropriate for some patients and alternative interventions should be utilised. The emphasis remains with the registered nurse's clinical judgement and individualised patient review and evaluation on the ongoing use of the alarms.

Several incidents have identified that the alarms have caused unnecessary levels of agitation for patients so are not an appropriate intervention for continued use.

Patients are encouraged to wear their own clothes and footwear as this encourages an individualised dignified approach. Social mealtimes wherever possible on the ward may also provide an opportunity for routine.

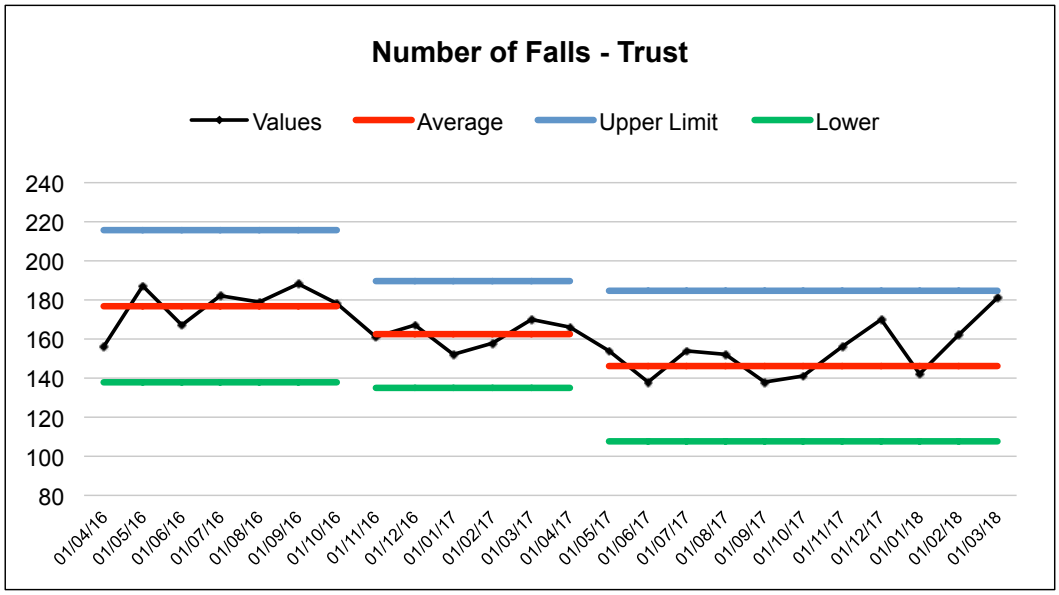


Chart 13: Number of Hospital Falls

The chart above shows the number of falls reduced from an average of 166 in 2016/17 to 147 in 2017/18. There has been some in month increases as operation pressures increase but the total number of falls for 17/18 compared to 16/17 reduced from 2045 to 1854. There has also been no adverse increase in the number of harm falls.

Improvements for 2018/19

- Further focused work is required as a result of the national audit of inpatient falls (November 2017) in the areas of poor compliance.
- EPR includes a risk assessment tool however this needs to be a focus for further work as compliance noted via incident reports shows that initial assessment and individualised care plans are not being undertaken.
- Ongoing emphasis on falls monitor training monitored monthly via medical device training.
- Development of falls awareness training as an essential skill for target clinical audience and included in the nurse induction programme, both linked to ESR introduced November 2017 with latest compliance figures of 74.48 %(Jan 2018).
- Focused work on tag bay nursing as an intervention for high risk patient with individualised organisation of care and interventions to minimise risk of falls.
- Enhanced support workers have been an invaluable care interventions for our most vulnerable patients however further investment in training and recruitment and retention is required

Healthcare Associated Infections (HCAIs)

The Trust monitors and reports infections caused by a number of different organisms or sites of infection. These include:

- Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- Methicillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- *Clostridium difficile* infections (discussed elsewhere)
- *Escherichia coli* bloodstream infections
- Central venous catheter infections
- Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE)

MRSA (Methicillin resistant Staphylococcus aureus) Bacteraemia:

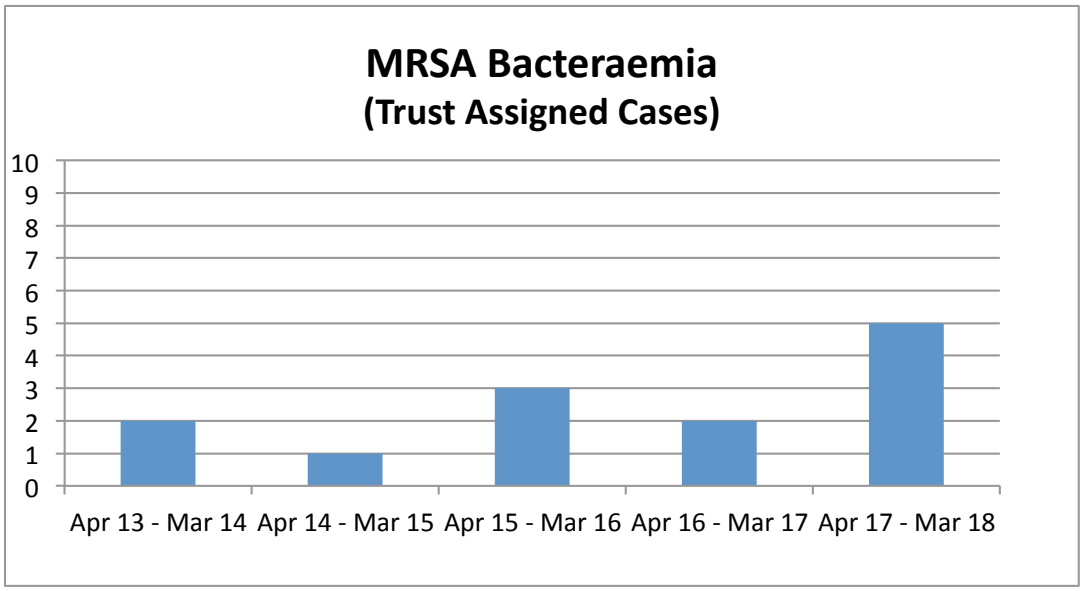


Chart 14: Number of MRSA Cases per year

We have seen an increase in MRSA bacteraemia during the last year, five bacteraemia have been reported since April 2017. All have been subject to a post infection review as per national process. Learning has been incorporated in the Trust Infection Prevention and Control action plan.

MSSA (Methicillin sensitive Staphylococcus aureus) bacteraemia:
MSSA bacteraemia is not subject to targets in contrast to MRSA bacteraemia. However, mandatory reporting of MSSA bacteraemia is required. In the year to date 20 cases have been reported. These are not subject to a formal post infection review, limited MSSA screening is in place for a select group of patients including patients with central venous catheters.

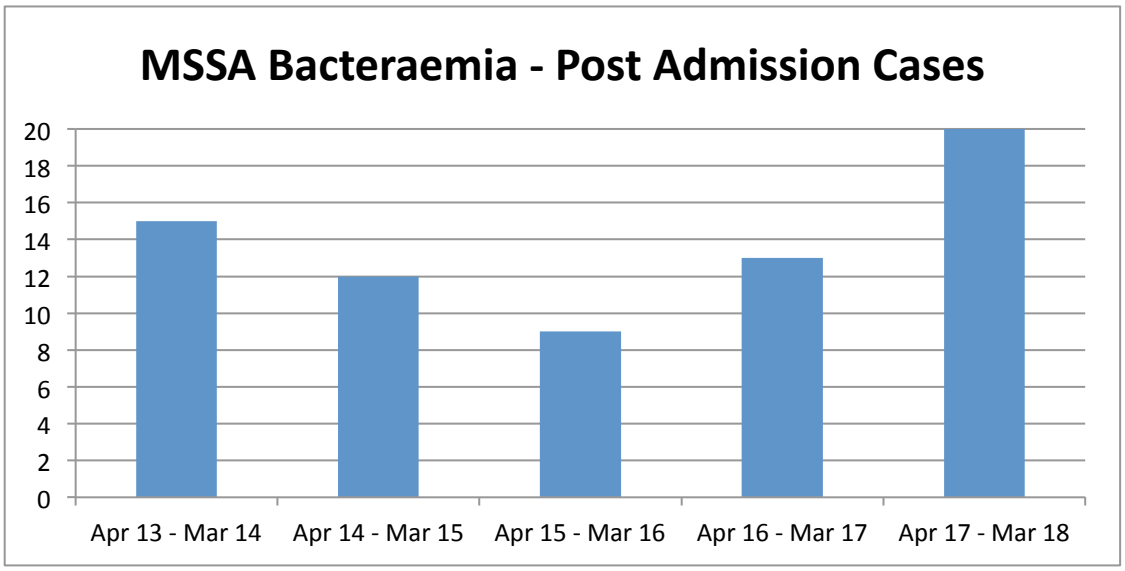


Chart 15: Number of MSSA Cases per year

E.coli bacteraemias:
There is currently no national reduction targets for E. coli bacteraemia, however mandatory reporting of E-coli's is required, and in the last year 45 cases have been reported to date. A review of cases indicates the majority of these are sporadic, although a small number are associated with the use of urinary catheters. Measures to tackle E. coli bacteraemia are ongoing within the organisation.

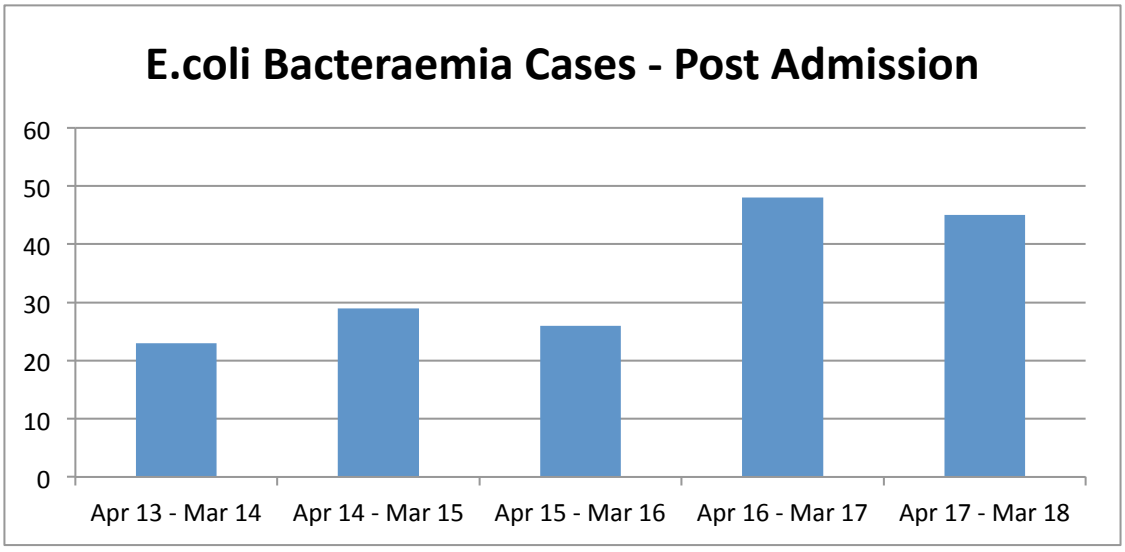


Chart 16: Number of E.coli cases per year

Central Venous Catheter Infections:
The Trust continues to report low levels of central venous catheter infections. For the 12 month period ending in February 2018, we reported a cumulative infection rate per 1000 CVC days of 0.48. This is well below our internal target of 1.0 per 1000.

Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE):
In line with national guidance from Public Health England, all overnight admissions to the Trust are screened for risk factors for colonisation/infection with CPE. All patients in whom a risk for colonisation or infection is identified are offered microbiological screening. Over the past three years, 11 patients have been identified who are colonised with CPE. The Infection Prevention and Control Team support clinical areas with enhanced infection control precautions when these patients are identified.

Key Priority Areas for the Infection Prevention and Control Team:
In addition to working to prevent healthcare associated infections as detailed above, the Infection Prevention and Control Team work to support improvements:

- Hand hygiene
- Appropriate use of invasive devices
- Aseptic Non-Touch Technique (ANTT)
- Cleaning standards
- Water and air quality
- Refurbishment of the hospital estate
- Training and education
- Audits and surveillance

Cancer Waiting Times

Delivery of the National Cancer Targets is a key part of effective cancer care and the Trust's performance around these targets is a significant indicator of the quality of cancer services delivery. The Trust continues to consistently achieve the cancer waiting times standards.

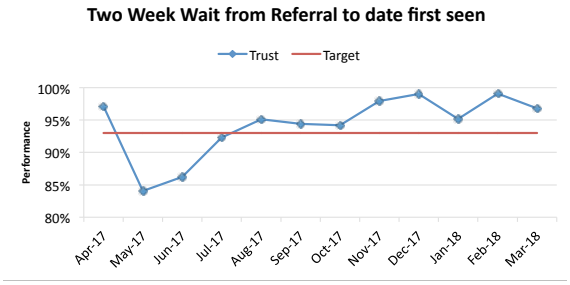
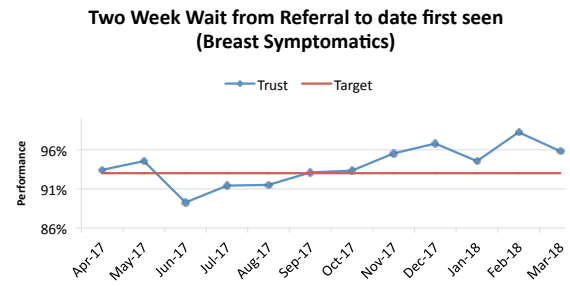
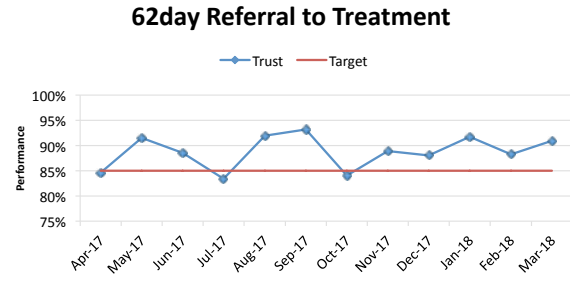
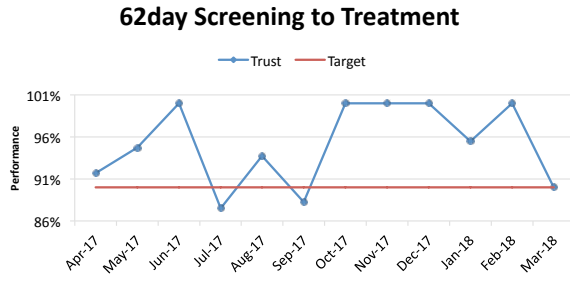
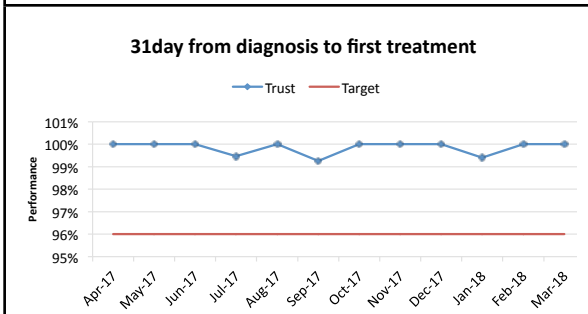
	The performance required for this target is 93% and Over the last year as can be seen from the chart the Trust had a large dip in performance. This unfortunately was due to the introduction of the new electronic system in the Trust. This has now been rectified and changes have been made with the team so that they are working very closely with the patient pathway coordinators. Performance is now on track.
	The performance required for this target is 93% and Since September 2017 this has been achieved. The Trust had a dip in performance from June to September again this was due to introduction of the electronic system as for the 2 week waits above.
	The performance required for this target is 85%. Unfortunately there have been a couple of months that the Trust has not achieved this target. There has been an action plan produced which has gone to the Directors and work is taking place with the teams to review pathways.
	The performance required for this target is 90% and the main issue has been bowel screening that has not achieved the target due to a variety of reasons, e.g. the patient feels well so there are many delays to diagnosis due to patient choice (holidays etc.) Also the conversion rate and numbers treated are low therefore the tolerance for breaches is extremely small making 90% often difficult to achieve.
	The performance required for this target is 96%. This is consistently achieved. The last recorded month failure of this target was June 2008.

Chart 17: Cancer Waiting

Alongside the national standards the Trust is looking to report on regional targets to ensure patients are transferred to specialist hospitals in a timely fashion. This will aim to:

- See Fast Track patients within 7 days

At present year to date 30% of patients are being seen within 7 days of referral which compared to the 46.8% we were achieving 2017. However it is felt to ensure the Trust meets the other targets this should be made a priority by all tumour sites. The Directors are supporting the improvements that need to be made.

- Carry out any Inter Provider Transfers (IPT) by day 38

The Trust has issues meeting the target of referring 85% of patients to tertiary centres by day 38 of their pathway. The year to date Trust position is 44.14%. Unfortunately this is little improvement from last year. The work on going with the teams and the improvements mentioned in the document will hopefully improve this performance. This is being closely monitored.

Improvement Plans 2018/19

Over the last year and continuing into 2018/19 the West Yorkshire and Harrogate Cancer Alliance have been reviewing all tumour site pathways and gaining agreement from Clinicians to follow these pathways. This gives the District General Hospitals a minimum data set that must be completed prior to referral on to the Tertiary centres and aids consistency across the region. Ultimately this will aid the inter provider transfer date which is referral by day 38.

The Trust has an action plan which is reviewed by the Weekly Executive Board (WEB); the next review is due at the end of April. This encompasses actions such as to ensure patients are seen within seven days of referral, patients are sent to tertiary centres by day 38, reviewing the length of time it takes for patients with a benign disease to be informed of their diagnosis.

Tumour site specific self-assessments for 2017/18 have been completed and reviewed by WEB; individual plans have been developed and considered against the quality surveillance team (QST) measures. The Clinical Commissioning Groups have reviewed and agreed the individual plans and have the power to request an external visit if necessary. The QST process for 2018/19 is dues to start in April and each tumour site will develop action plans based on their new self-assessment.

The Trust has achieved some funding from the Cancer Alliance to pilot four schemes, see below:
Vague symptoms pathway

- FIT Testing (Faecal Immunochemical Test)
- Workforce redesign , including advanced Practitioners in cellular pathology and workforce role redesign in endoscopy

These will commence in April 2018 and will run for 12 months, the teams will report to the Cancer Alliance and the Trust. The main aim of all the schemes is to try to improve earlier cancer diagnosis.

Cancer Site Specific and Specialist Palliative Care teams update

The Trust employs a number of specialist staff in roles to support the delivery of cancer care, and end of life care in both cancer and non-cancer patients.

Acute Palliative Care

A pilot commenced in October 2017 at Huddersfield Royal Infirmary. The aim of the pilot was to provide acute palliative care In the Emergency Department and Medical assessment unit, to reduce admissions by appropriate nurse led triage and management of palliative and end of life patients and where possible to facilitate rapid discharge.

Across the board, the aim is to identify patients in the last 12 months of life, and to offer an holistic assessment to them including advanced care planning which will facilitate admissions avoidance (where appropriate).Increase palliative care and end of life care knowledge for ward/departmental staff in the delivery care in the last days/hours of life.

Palliative Care in Stroke
A pilot commenced on the Stroke unit in October 2017, this has funded a specialist palliative care nurse to work 2 days a week solely on the stroke unit. The nurse is working with whole multidisciplinary team to encourage thought around decisions about end of life care and nutritional issues. The nurse is joining the family meetings to aid discussions around advanced care planning to ensure that quality of care improves.

Lung Cancer Follow-up
A recent pilot of nurse led follow-up for patients with lung cancer has shown increased compliance with the cancer pathway due to increased consultant capacity for new patients. With recently agreed extra funding this will be formalised during 2018, where further nurse led follow-up can be optimised.
Cancer Psychological Services

Psychology services for cancer patients have developed significantly during the last year. Since March 2017 all patients with cancer have some access to level 4 psychological support, this is in line with Supportive and Palliative Care NICE Guidance. For the first time each cancer site specific team now has at least one member who has completed training to deliver level 2 psychological support to their patients and carers. The individuals who have completed their level 2 training have on-going access to clinical supervision. In recognising that the cancer care coordinators deliver a large element of face-to-face care with cancer patients, the clinical psychologist also offers the individuals in this role an appropriate level of supervision and was presented with the 'Going the Extra Mile' award at this year's Celebrating Success awards.

Living With and Beyond Cancer
Cancer patients now access to regular health and wellbeing sessions, the aim of these sessions is to empower patients to self-manage following completion of their cancer treatment. The sessions support physical and emotional wellbeing whilst also promoting a healthy lifestyle. Empowering the patients enables individual teams to further stratify follow-up for low-risk (of recurrence) patients.

To meet the changing landscape of cancer treatment and a patient's needs, specialist nurses (working closely with the designated named cancer site specific consultant) have and are developing nurse led clinics: assessing appropriate new cancer fast track patients, undertaking biopsies and ordering investigations, breaking the news of a new cancer to patients as well relevant cancer follow up (appropriate to the training level and competencies of the Specialist Nurse.). A crucial part of specialist nurses role is also in the assessment and interventions/care of patients during the patient's treatment, recovery and living with the consequences of the treatment.

The advanced roles that specialist nurses are undertaking in the patient's pathway means that there are changes in professional roles and service provision for patients. As well as piloting nurse consultant posts in cancer teams and how they help improve the patients experience and pathway to treatment, new roles are being considered. One such role is the 'Cancer Care Co-ordinators'.

These are non-registered roles, but provide support to patients and co-ordinate all the other referrals to services. They include traditional non specialist parts of cancer nurse specialist (CNS) roles. Cancer Care Co-ordinator posts are a valuable resource in the patient's management for low level specialist intervention once training and experience has been gained. They are a first port of call for patient's questions and queries, emails and phone calls. Baseline assessments and continuity for patients having access to the service can be through these posts.

Throughout 2017 CHFT cancer teams will be working in line with the recommendations from the World Class Cancer Outcomes Strategy 2015-2020 and the National Cancer Patient Experience Survey, we will deliver the living with and beyond cancer agenda, offering health needs assessments at strategic point in the patients pathways, care plans with long term side effects and how to access specialist services at a time when patients need them as well has health and well-being events being offered.

Stroke

There are more than 100,000* strokes in the UK each year, that is around one stroke every five minutes in the UK.

- Between 1990 and 2010 the incidence of strokes fell by almost a quarter. Around 1 in 6 men will have a stroke in their life and around 1 in 5 women will have a stroke in their life.

The rate of first time strokes in people aged 45 and over is expected to increase by 59% in the next 20 years (between now and 2035). In the same period, it's estimated that the number of stroke survivors, aged 45 and over, living in the UK is expected to risk by 123%.

It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years. By focusing on improvement in stroke care, patient outcomes can be vastly improved.

The Trust has the following aims to strengthen and improve stroke services:

- Patients are admitted to a stroke bed within four hours
- Patients spend 90% of their hospital stay on the Stroke unit

Improvements in 2017/18:

The whole of the Stroke unit is now on one floor which aids seamless flow for the patients, relatives, Nursing, allied healthcare professionals and doctors. As patients progress from being acutely ill to their next stage of rehabilitation the staff seeing them can discuss goals with the staff caring for them and ensure their care is not disrupted in any way.

A pilot commenced on the Stroke unit in October 2017, this has funded a specialist palliative care nurse to work two days a week solely on the stroke unit. The nurse is working with whole multidisciplinary team to encourage thought around decisions about end of life care and nutritional issues. The nurse is joining the family meetings to aid discussions around advanced care planning to ensure that quality of care improves and all parties are happy with the pathway.

The monthly Clinical Governance meeting for the whole multi-disciplinary team has been reviewed so that it is more inclusive of all staff. The first part of the meeting is around the departmental business i.e. Risks, Governance, mortality, targets etc. and
the second half is around learning e.g. learning from complaints, incidents mini audits undertaken by staff all grades of staff are encouraged to attend.

Following the pilot held on one of the rehabilitation wards, the team has implemented a change to working patterns for doctors, therapists, nurses and social services. The team has secured a new consultant who will hopefully start in the summer of 2018. Each morning there is a multi-disciplinary team meeting to discuss every patient and what is happening to the patient, their needs any risks that need to be addressed and the goals that day and the next week. This has led to increased patient and family satisfaction and also staff satisfaction as they feel they are working as a team.

Recruitment has been difficult and to try to improve this, development band 6 posts have been put in place. Also to aid succession planning to the small team of thrombolysis nurses two development posts have been appointed to; initially these will work partially on the ward and as a thrombolysis nurse. This has been a successful way forward for recruitment

The first chart relating to the four hour direct admission is variable. Any patients that are brought to CRH for thrombolysis are all admitted. The trend is that the patients that are not achieving this target are the patients that are not initially diagnosed as a stroke or attend the HRI Emergency Department (ED). It is felt with the plan for the assessment beds in the ED will reduce number of stroke that are miss diagnosed and will ensure patients are seen by the right clinician initially.

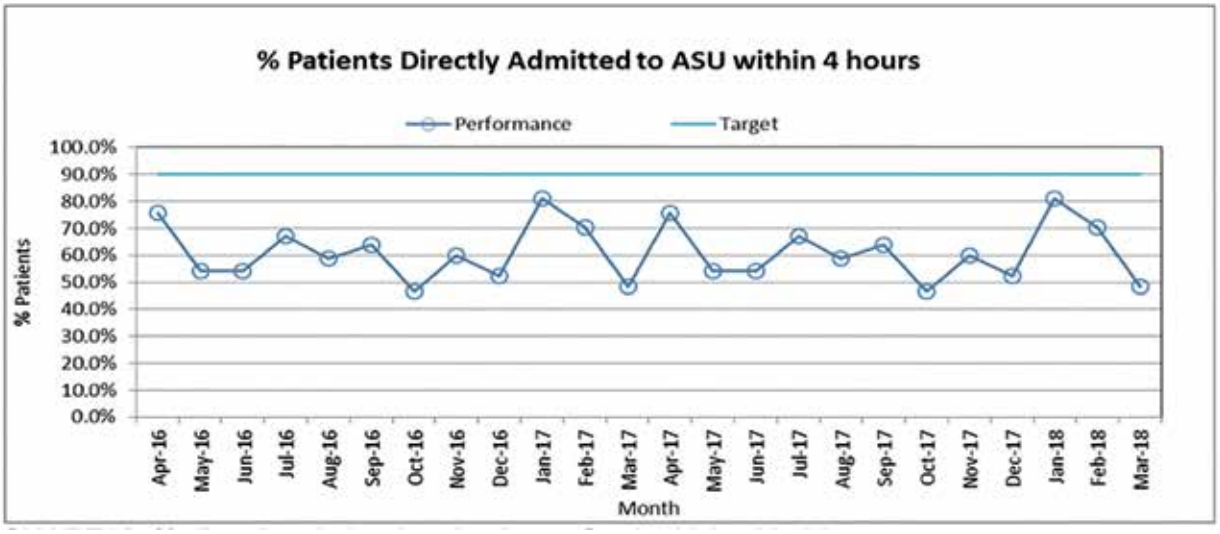


Chart19: % directly admitted to the Acute Stroke Unit with 4 hours

The second chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward. Performance has remained variable throughout the year; though there has been a step change over the last 18 months. Again patients need to be admitted to the Stroke unit immediately so that this can be achieved.

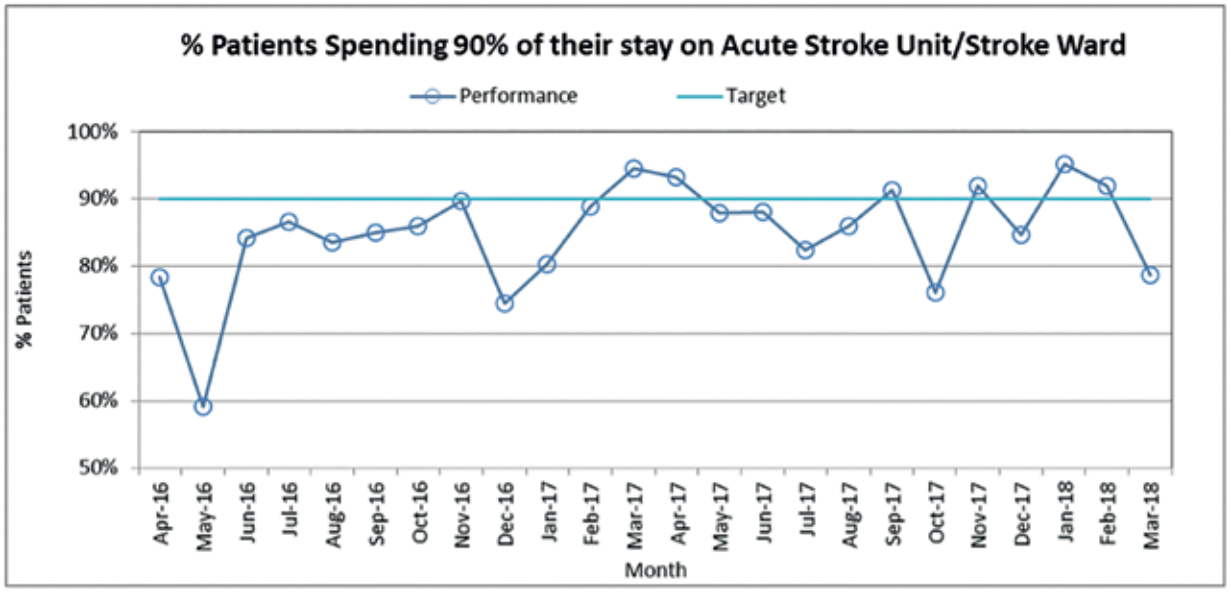


CHART 20: % of patients spending 90% of their stay on the ASU

Plans for 2018/19

The main area that the team wish to improve is the commencement of a stroke assessment area in the Emergency Department. The consultant and thrombolysis nurse will see patients with neurological conditions and determine whether they are a stroke or not. This will ensure that the patients are directed to the correct care area immediately; which in turn should result in better outcomes for patients as they will be cared for by clinicians with the specialist knowledge.

Discussions are underway with the CCG's regarding rehabilitation and what environment is the best area for the patients to be cared in; i.e. in the community rather than in a hospital.

The team wish to improve their SSNAP score (Sentinel Stroke National Audit Programme) to an A from a B which is another indicator that the Trust is proving excellent care to their patients.

End of Life Care

Improving end of life care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die, when their death is expected, it is vital that they receive appropriate end of life care.

End of life care can be complex because of the special needs of many at the end of life and because of the need to co-ordinate and integrate a wide range of services across different sectors. However the rewards for getting it right are huge. Personalised, integrated care at the end of life can transform the experience for the individual, their family, and the staff caring for them.

Many of the actions from 2016/17, and our achievements linked to these, remain valid, and significant progress has been made during 2017/18 in many areas. However, it is clear that continued work is needed to improve both the recognition of patients in the last year and last days of life, and communication with them and their families. Linking together the work of the Learning from Deaths (LfD) umbrella, the EOLC strategy, which is to be reviewed and updated this year, the EOLC steering group and other initiatives will enable this improvement.

Key issues, achievements and suggested plans for 2018/19:

Better identification/recognition of patient in the last year: the preliminary feedback from the Macmillan MAU/ED project at HRI has identified high numbers of patients presenting acutely who are likely in the last year of life. Suggested improvements include the use of prognostic tools by clinical teams. Earlier recognition of these patients in community will also be needed.

Better management of the last days of life: the use of the ICODD (Individualised Care of the Dying Document) has fallen since the advent of electronic records in May 2018. Work has begun to create a version of the ICODD within EPR. A dedicated learning DVD resource has been created and will be added to the learning platform for clinical staff, and other resources also developed.

Specialist Palliative Care Team (SPCT) activity: we have been recording patients' phase of illness and Karnofsky performance score for almost three years now, and the proportion of patients referred to the SPCT who are either deteriorating or actively dying on first assessment has increased threefold and fourfold respectively in the last two years, reflecting a much sicker and needier hospital population. A broader skill mix within the team and collaboration with the frailty team and discharge team may be one way to address these pressures.

Education for clinical staff: communication skills training will be delivered to 15% of staff in targeted areas, and all new nurses joining the Trust receive essential skills training in EOLC. Hundreds of staff have been educated by members of the training team, in a variety of settings. New resources are being added to ESR, where appropriate levels of EOLC training will be delivered to all staff, dependent on their roles. Linking learning on EOLC more formally to the appraisal and revalidation process would also be a helpful process.

Audit, review and user experience: plans are in place to obtain more robust feedback from bereaved relatives by way of an initial pilot within the stroke wards, and later in the year, our participation in the national Care at the End of Life (NACEL) audit will incorporate bereaved relatives' feedback, as well as audit of organisational standards and clinical care given to patients dying in May 2018. The requirement for all deaths to be reviewed by consultants, and for a selection to undergo more critical analysis by the team of structured judgement reviewers, will also inform the process by which we address deficits within care delivery and learning needs.

Seven Day Services

A series of clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh. Ten standards were agreed and have been rolled out across the NHS England in acute hospitals. Four of these standards were identified as priority clinical standards on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The purpose of the standards are to deliver safer patient care, to improve patient flow through the acute system, to enhance patient experience of acute care, to reduce the variation in appropriate clinical supervision at weekends and potentially, to mitigate the excess mortality that has been shown in large studies to be associated with weekend admission to hospital.

The Trust participates in regular surveys to gauge progress and compliance against these four priority standards. In March 2017, all four priority standards were audited, in September 2017 only standard 2 was audited. CHFTs most recent results are below;

Survey Results			
Standard	**Overall Result**	**Target**	**Survey**
Standard Two- Time to first review	93%	90%	September 2017
Standard Five- Access to Diagnostics	80%	90%	March 2017
Standard Six- Access to Interventions	100%	90%	March 2017
Standard Eight- Ongoing review	90%	90%	March 2017

CHFT was one of only four acute Trusts in the north of England to achieve the target on standard 2 in the September 2017 survey. These results have been formally fed back to the Trust Board and some areas of focus identified, particularly regarding access to diagnostics.

The next survey will be in April 2018. In this survey all four priority standards will be measured. In preparation for this the Trust lead of seven day services is working with clinicians and managers to keep delivery of seven day services as a priority for the organisation, asking for progress against not only the four priority standards but also evidence that the further six are being considered in service planning.

Patient Experience

1. Aims and Objectives of Work

Measuring patient experience is essential in order to assess the delivery of the Trust's vision: Together we will deliver outstanding compassionate care to the communities we serve along with the strategic goal of: Transforming and improving patient care.

Analysis of patient feedback helps us to better understand our patients' expectations, their experience and their satisfaction. For example their views of the environment in which their care and treatment was delivered, whether they were kept informed, whether they were treated with respect and dignity and how their interactions with staff made them feel.

It is important that the feedback is used to influence changes in practice; this may often be about the small things as well as any large system changes. Staff from across the Trust recognise the importance of listening and responding to patient and carers views, this is championed through the representatives on the Trust Patient Experience and Caring Group.

2. Feedback methods

The primary method of measuring the patient experience in the Trust remains through the Friends and Family Test (FFT) which is now well established across all inpatient and day case areas, as well as in the A&E and outpatient departments, maternity services and across community services. More innovative approaches continue to be introduced to gather feedback and create opportunities to 'listen', through a range of feedback options that sit alongside the more formal methods of FFT, complaints, patient advice service and surveys.

Over the last 12 months wards and departments have used a variety of other methods to encourage patient feedback, examples include direct contact through rounding by the ward managers and matrons, debriefs, guest books and graffiti boards. Opportunistic engagement is also carried out to gather service user opinions to support improvements the teams are taking forwards, as well as more formal enquiries to support service evaluations.

3. Friends and Family Test

The FFT question asks "How likely are you to recommend our ward / department to friends & family if they needed similar care or treatment?" Performance is monitored internally against national performance baselines.

Top 20%	Super Green
50%-79%	Green
21%-49%	Amber
Bottom 20%	Red

Information for the year for the FFT response rate as well as the percentage who would recommend the service is given below.

2017/8 % Response Rate & Would Recommend

	2017/18 Response Rate	2017/18 Would Recommend
Inpatient	31.4%	96.9%
A&E	10.2%	85.0%
Maternity	41.0%	97.6%
Community	6.5%	90.0%
Outpatients	10.1%	89.7%

4. Local Quality Improvement Work

The Trust Patient Experience and Caring Group has taken forward a number of priorities over the last 12 months, below are some examples of these.

4.1 PRASE (Patient Reporting and Action for a Safe Environment:

The Trust has worked with the Yorkshire & Humber Improvement Academy using the PRASE survey, which are conducted by trained volunteers at ward level. This approach enables patients to provide anonymised feedback (positive and negative) on the safety and quality of care experienced during their ward stay.

The questions are linked to 8 safety domains:

- Communication and teamwork
- organisation and care planning
- access to resources
- the ward environment
- information flow
- staff roles and responsibilities
- staff training
- delays

Results for surgical wards have shown some excellent results, with feedback around 'communication and team work' and the responsiveness of staff to answering buzzers being particularly positive. Some opportunities for improvement were to improve 'organisation and care planning', with one ward conducting improvement work to help ensure staff and patients are aware of the plan of care and another ward making better use of ward space. The initial surveys were undertaken on some of the surgical wards, they have now been rolled out to other areas - medical and paediatric wards.

4.2 Experience Based Co-design (EBCD):
The Trust's Patient Experience and Caring Group have championed the use of EBCD as an opportunity for service users and staff to come together to design, monitor and improve the care provided. The Trust held two events during 2017 related to the reconfiguration of medical services - Respiratory and Frailty.

Outputs from the frailty event included working with patients to:
- Develop a patient/carer leaflet (draft shared with those present)
- Include information about tests, results and follow ups on the leaflet – discuss with patients/carers to assess whether this would provide the information they need (draft has been sent to EBCD participants)

Other ideas for improvement have been taken forward via the Frailty Operational Group:
- Development of staff competencies, including implementing advanced care plans
- Training staff to advanced practitioner level

An event relating to End of Life care has also been held, dignity symbols, a bereavement card and a 'coffee mourning' were examples of ideas discussed and agreed and are being taken forward through the end of life care group.

A final event relating to high risk antenatal services is scheduled for May 2018.

4.3 Divisional reporting:
The reports received quarterly from divisions have been redesigned in order to increase the opportunities to share:
- how teams have responded to patient feedback along with examples of innovation
- examples of improvement work related to the experience of service users with one of the 9 protected characteristics and any improvements made to make the physical environment accessible to all
- any opportunities taken to involve our patients / public in service improvements
- public consultation on planned projects or user reference groups feeding back their views

Examples from reports include:
- new chairs have been purchased following a trial by parents to help promote skin to skin with babies on the neonatal unit
- paediatric diabetes team introduced a new program of diabetes education sessions for our young patients with type 1 diabetes and wellbeing days held at a local climbing centre.
- a roadshow was held on the new food provision contract which included a food tasting session and a competition to design a regional dish. Excellent feedback was received regarding the quality of the food and a new finger food menu introduced as a result of the feedback.
- dementia and delirium and visually impaired: Coloured plates, cups, bowls and side plates now available for patients on a number of wards at HRI. When trialled positive feedback was also received relating to the yellow crockery as being suitable for the visually impaired too
- responded to feedback from young people that there was a lack of facilities for older children on the children's ward. Staff gathered opinions from young people through the use of a mood board and have developed a teenage room.
- the surgical assessment unit (SAU) placed posters behind the bed with information about visiting hours, mobiles on silent, use of dayroom, promoting graffiti boards; also developed an ambulatory area to create a more comfortable environment
- Critical Care: using feedback from patients attending the follow-up clinic to better prepare patients with coping strategies to manage their future mental well-being; staff attended a regional afternoon tea event with staff and service users and plan to establish these locally as an opportunity to share experience and feedback
- a room on the neonatal unit has been refurnished to be used by parents as part of their preparation for discharge home. All clinical equipment has been removed and it has new family friendly furnishings. Feedback has been excellent.

5. National surveys

For all of the national surveys scores each question is scored out of 10, a higher score is better. Trust scores of each question in the survey are also compared with the range of results from all other Trusts that took part. An analysis technique called the 'expected range' is used to determine whether a Trust performs 'about the same', 'better' or 'worse' than other trusts. This analysis is based on a rigorous statistical analysis and therefore any scores outside the expected range means it performs significantly better / worse than what would be expected and unlikely to have occurred by chance.

Inpatient: published May 2017, CHFT were reported as scoring **about the same** for all but one of the questions. The Trust was reported as scoring **better** than the majority of other Trusts for the question - 'If you brought your own medication into hospital, were you able to take it when you needed to?'

Emergency Department: published October 17, CHFT scored 'about the same' for all but one question –'Did a member of staff tell you about medication side effects to watch for? The Trust scored worse for this question.

Children and Young People: published November 2017, CHFT scored 'about the same' for all but one question: Did the ward where your child stayed have appropriate equipment or adaptations for your child's physical or medical needs? The Trust scored worse for this question.

Maternity: published January 2018, CHFT scored about the same for the majority of questions.

There were two questions where the Trust scored 'better':

- Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?
- Did you feel that midwives and other health professionals gave you active support and encouragement about feeding your baby?

There was one question where the Trust scored' worse':

- Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?

For the questions where the Trust scored 'worse' the services are taking forward actions. Progress with these will be monitored through their internal governance arrangements and reported through Divisional reports to the patient experience and caring group.

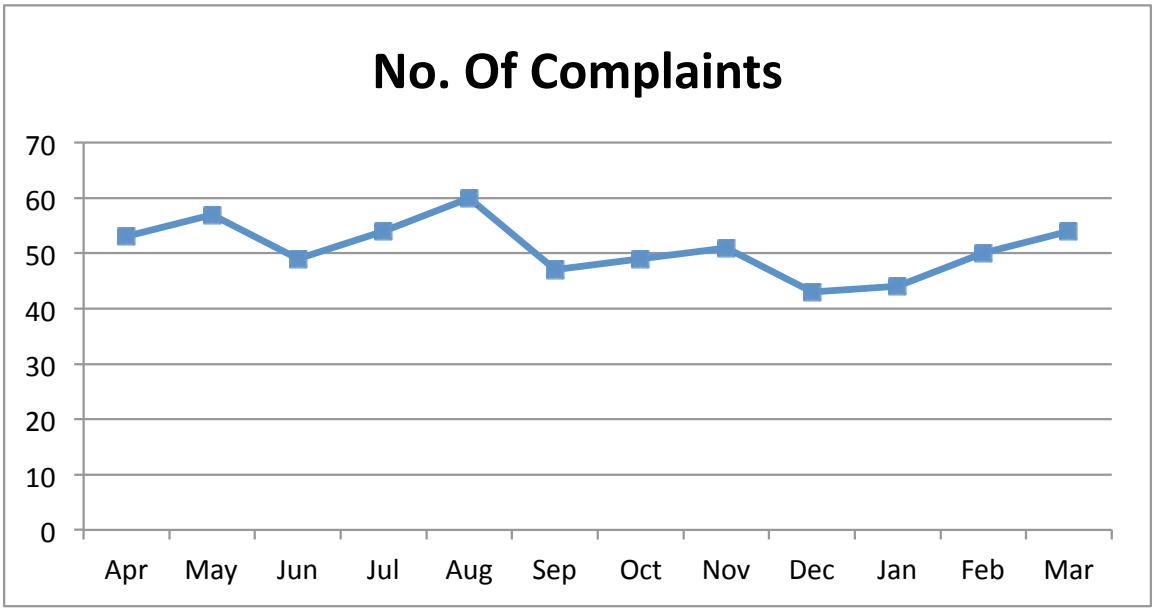
Staff posters have been produced to highlight some of the key messages from the surveys as an opportunity to share what patients say we do well, recent service improvements and any further actions to be taken.

			2016 Case-mix Adjusted			
Question		Number of respondents for this Trust	2016 Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	National Average Score
Clinical Nurse Specialist						
Q17	Patient given the name of the CNS who would support them through their treatment	446	86%	87%	93%	90%
Q19	Get understandable answers to important questions all or most of the time	329	85%	85%	92%	88%
Support for people with cancer						
Q20	Hospital staff gave information about support groups	324	75%	79%	89%	84%
Q22	Hospital staff gave information on getting financial help	233	48%	49%	64%	56%
Your overall NHS care						
Q56	Overall the administration of the care was very good / good	462	93%	86%	93%	89%

The Trust's lead cancer nurse is working with each cancer team to deliver individual plans based on their results. The main focus for the teams is clinical nurse specialist interaction and the continued development of the cancer information service.

Complaints (Type and Severity)
In 2017/18 the Trust received a total of 615 complaints, a 0.3% decrease in complaints received from 2016/17 to 2017/18.

The profile of the spread of the complaints received by month is given below.



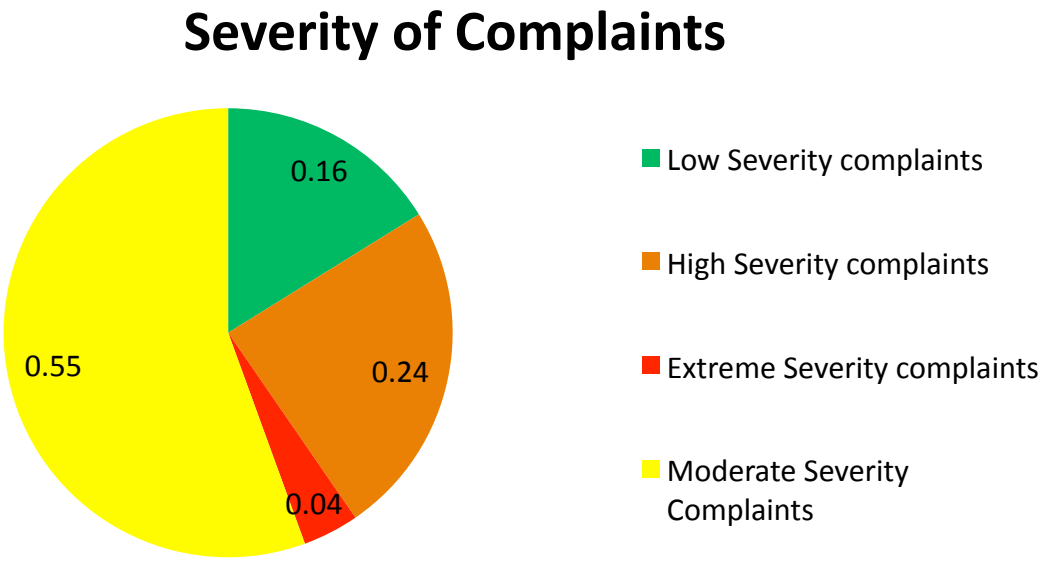
Number of complaints per month 2017 /18

The average number of complaints received each month by the Trust in 2017/18 was 51. The Trust received the highest number of complaints in May, the period during which the electronic patient record (EPR) was implemented...

Severity of Complaints Received
Complaints are triaged and graded on receipt for severity. In 2017/18 the Trust moved from a four tiered rating (green, yellow, amber, red) for complaints to a three tiered rating (green, amber, red). The initial grading is determined by the Patient Advice and Complaints Department based on the patient experience described in the complaint.

CONSEQUENCE	LIKELIHOOD OF RECURRENCE				
	Frequent	Probable	Occasional	Uncommon	Remote
Serious	HIGH	HIGH	HIGH	MEDIUM	MEDIUM
Major	HIGH	HIGH	MEDIUM	MEDIUM	MEDIUM
Moderate	HIGH	MEDIUM	MEDIUM	MEDIUM	LOW
Minor	MEDIUM	MEDIUM	LOW	LOW	LOW
Minimum	LOW	LOW	LOW	LOW	LOW

In 2017/18 the majority of complaints (50%) were graded as orange, 5% (31) complaints were graded as red (extreme severity) as shown in the pie chart below.

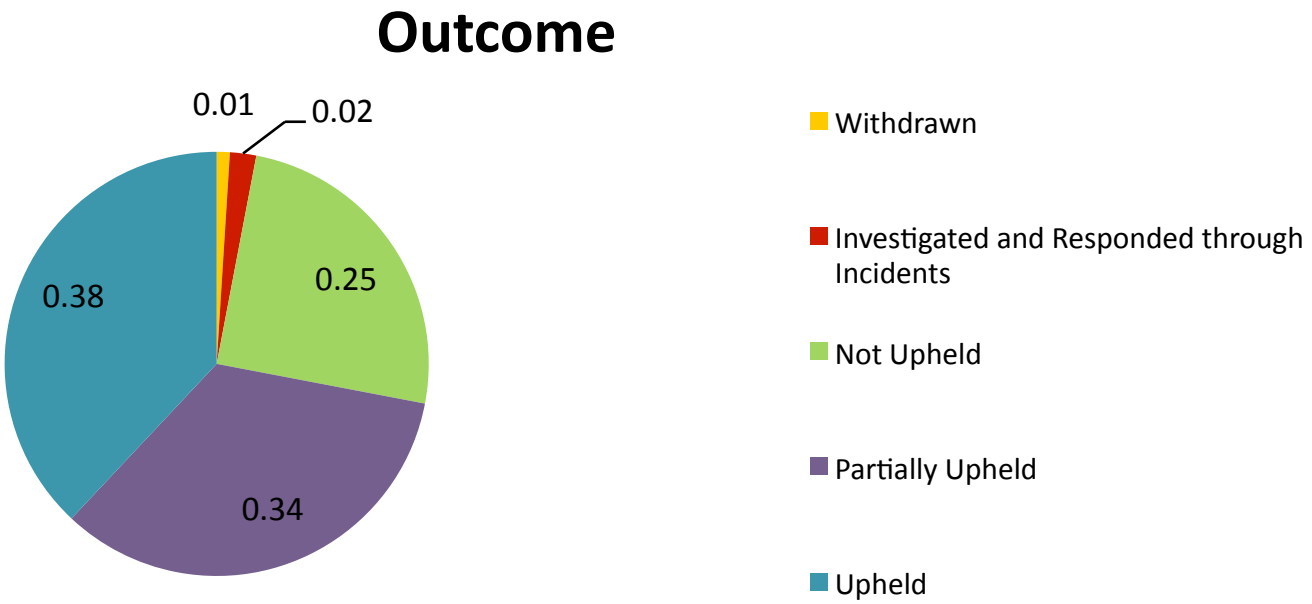


Red Complaints Data
Complaints that are triaged as red are reviewed at a red panel meeting and are linked to an incident where appropriate.

In 2017/18 the Trust received a total of 31 red complaints.

Acknowledgement Time
99% of the complaints received in 2018/19 were acknowledged within three working days.

Complaints Closed
The Trust closed a total of 559 complaints in 2017/18; this is a decrease of 17% from 2016/17. Of the 559 complaints closed, 46% were upheld, 36% were partially upheld (NHS Digital counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 77%), 16% were not upheld, 1% related to an incident and 1% were withdrawn.



The Trust will re-open a complaint for one of the following three reasons.
I. response failed to address all issues and concerns
II. new issue and concern
III. Parliamentary and Health Service Ombudsman Investigation

The Trust re-opened a total of 71 complaints in 2017/18. This is a 1% decrease from 2016/17.

3.7 Timeliness of Complaints Responses
There has been significant work undertaken by the Trust in 2017/18 to improve the timeliness of responses to complainants. During the month of December 2017 the Trust closed a total of 70 complaints reducing the backlog of breaching complaints from 66 to 40, a reduction of 39%.

Processes have been put in place to closely monitor timescales and escalate any delays in response to ensure that all complainants receive a timely response. The total number of overdue complaints at the end of 2017/18 was 31.

The top three subjects of complaints for the Trust are as follows:

Subject	Percentage	Increase /decrease from 2016/17
Communications	↓ 22%	8%
Patient Care (including nutrition and hydration)	↓ 19%	8%
Clinical Treatment	↓ 19%	8%

Communications, patient care (including nutrition and hydration) and clinical treatment remain the top three subjects of complaint in 2017/18.

Parliamentary and Health Service Ombudsman Complaints
The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level. The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider.

The table below shows figures relating to the Trust is a time with the figures relating to the Trust;

	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Number of Complaints Received by PHSO	1	2	3	1
Number of Complaints accepted for investigation by the PHSO	1	2	3	1
Number of Complaints the PHSO Upheld or Partly Upheld	1	3	0	2
Number of Complaints not upheld	3	0	1	0

Seven cases were accepted for PHSO investigation between April 2017 and March 2018. During this period the PHSO also concluded seven complaints against the Trust Of these eleven, three complaints were not upheld and four were upheld /partially upheld.

Learning from Complaints

The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we aim to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this and each service and division is required to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

Complaints data and learning from complaints is reported quarterly to the Trust's Patient Experience Group to ensure that learning is shared across the Trust.

Some examples of learning from complaints for each division is given below.

Complaints Learning:

Medical Division		
Issue:	**Findings:**	**Learning:**
Clinical Treatment:		
Care and treatment of patient whilst using emergency services. Different information about diagnosis given to family. Patient discharged, then re-admitted a few days later with pneumonia and subsequently died.	Difficulties reaching a firm diagnosis due to clinical symptoms, once diagnosis made patient appropriately commenced on antibiotics. Error on discharge summary - wrong diagnosis listed. Antibiotics should have been commenced within the first 24 hours to give the patient the best possible chance of recovery.	To share the patient's experience in the Junior Doctor Forum regarding the importance of commencing antibiotics in a timely manner To share patient's experience in the next departmental governance meeting - Junior Doctors will use the learning to ensure they start patients with similar issues on antibiotics sooner. Further training in the use of EPR for junior doctors - Junior doctors will be competent in the use of EPR.

Family and Specialist Services Division		
Issue:	**Findings:**	**Learning:**
Attitude of Staff:		
Poor attitude and communication of a Sonographer with patient's relative during an appointment. The Sonographer would not allow the relative to go in with mother for the scan even though daughter tried explaining that the carer was going to leave the room allowing space for the daughter to stay.	The Sonographer offered her sincere apologies for the distress caused and appreciated she should have offered the opportunity of the daughter swapping places with the carer.	The Sonographer has reflected on her behaviour and attitude, and in future will ensure that she gives the opportunity to ensure that the appropriate person remains in the room to support the patient. The standard letter template will be revised to inform patients that only one escort can stay in the room with the patient during the procedure and signs erected in the room informing patients of the one escort policy.

Surgical and Anaesthetics Division		
Issue:	**Findings:**	**Learning:**
Clinical Treatment:		
Complaint regarding the care and treatment of a child who underwent an adenoidectomy at HRI. The patient was discharged, still vomiting and had not been seen by a Doctor since starting to vomit, neither kept fluid down or eaten. Parents were informed this was normal and left. 24 hours later the child was very weak/ dehydrated and still vomiting. Parents contacted the assessment unit and were told to attend. Parents were not informed on the telephone that they meant attend at CRH not HRI where the surgery had taken place. Consequently they had to take their child to emergency services at HRI as the child was so poorly.	Morphine was given for pain relief but anti-emetics were not prescribed for vomiting. Vomiting was not escalated to the anaesthetist. Nurse 'assumed' patient had eaten toast. Leaflet given and was not clear at which hospital the assessment unit was.	Future episodes of vomiting to be escalated to anaesthetics for prescription of anti-emetics. If vomiting occurs nursing staff must check with anaesthetist they are happy for the patient to be discharged. Nursing staff now documenting exact fluid and food intake. Nursing staff will now ensure that patients are fully aware of where the assessment unit is. Clarity on communication - shared with the ward team so they are able to reflect on their approach.

Parliamentary Health Service Ombudsman (Medicine)		
Issue:	**Findings:**	**Learning:**
Delay in Diagnosis :		
The complainant felt her father's care and treatment was unsatisfactory and she is unhappy that his diagnosis was delayed	The PHSO decided to partly uphold the complaint. They found that the Trust failed to identify promptly that the patient had metastatic spinal cord compression (MSCC) and are confident that there were sufficient clinical pointers to suggest a suspicion of MSCC, a whole spine MRI should have been done within 24 hours.	Flowchart for diagnosis of MSCC implemented which is rolled out in Doctor training.

Areas for Improvement

An update against the key priorities for 2018/19 for the complaints and patient advice service are:

- Sustain timely responses to complainants;
- Update the complaints training to modular based training, containing an online modular that complaints investigators can complete.
- Continue to focus on quality responses that address all aspects of complaints and introduce the Trust new response template.
- Analyse responses from satisfaction survey, to identify further areas for improvement.
- Improve identification of sharing and learning from complaints within the Trust learning from adverse events framework

Performance against relevant indicators and performance thresholds from the Standard Operating Framework

Indicator	Threshold	Performance	Achieved
Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	90%	83.21%	No
Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted	95%	93.03%	No
Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	93.75%	Yes
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	90.61%	No
All cancers: 62-day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	 85% 90%	 88.71% 94.87%	 Yes Yes
All cancers: 31-day wait for second or subsequent treatment , comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	 94% 98% n/a	 99.26% 100%	 Yes Yes
All cancers: 31 day wait from diagnosis to first treatment	96%	99.83%	Yes
Cancer: two week wait from referral to date first seen, comprising: • all urgent referrals (cancer suspected) • for symptomatic breast patients (cancer not initially suspected)	 93% 93%	 94.10% 93.88%	 Yes Yes
Clostridium difficile – meeting the C. difficile objective	21	8	Yes
Maximum 6-week wait for diagnostic procedures	99%	99.59%	Yes
Data completeness: community services, comprising: • Referral to treatment information • Referral information • Treatment activity information	 50% 50% 50%	 100% 99.73% 100%	 Yes Yes Yes

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch, Governors and local providers

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group

RE CHFT Quality Accounts Feedback 2017/18
We were pleased to receive and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The following statement is presented on behalf of NHS Greater Huddersfield CCG and NHS Calderdale CCG.

The Quality Account is again a comprehensive assessment of the levels of quality and is consistent with the Commissioners understanding of quality within CHFT; we note the continued commitment to quality despite the increasing demand and financial challenges. The account describes progress in many areas against national targets and local ambitions which is helpful and demonstrates transparency. This statement will reference areas as CCGs we are pleased to see the progress made, and others where we feel the account could be strengthened.

We recognise the improvement work the Trust has undertaken in the past year, particularly in relation to the implementation of the Electronic Patient Record (EPR) and the number of benefits this has brought about, however, in the interest of transparency the CCGs feel it would be beneficial to note some of the initial issues that the implementation raised; particularly in relation to access to patient appointments and correspondence with external agencies.

We welcome the progress made in relation to the identified priority areas for 2017/18, and are reassured to see the improvement in sepsis screening as a result of ERP, the improved partnership working resulting in better discharge planning and reduced length of stay, and the Trusts commitment to learning from complaints. However it may also be pertinent to include information on the challenges of responding to complainants in a timely manner.

We recognise the improvement work and reduction in the number of falls in hospital and welcome the plans to continue this work into 2018/19. We note that you continue to perform well against the National Cancer Waiting Times targets and are pleased to see your continued commitment to the West Yorkshire and Harrogate Cancer Alliance.

The CCGs commend the hard work undertaken to improve mortality rates, HSMR and SHMI, and are pleased to have had CCG representation working with you to support this achievement.
We note your open account of the Care Quality Commission (CQC) inspection and the improvements made against the action plan. We were pleased to support you with the mock inspections and open conversations with the inspectors prior to the visits. Like you we await the outcome of the recent unannounced and planned visits.

The CCGs are pleased to see that the priorities for 2018/19 will continue support system wide improvement and will build on last year's priorities:
- Care of the Acutely Ill Patient
- Patient Flow
- End of Life Care

The rationale for why these have been chosen, the work to be carried out and what the Trust is trying to achieve is clearly articulated and supported by the commissioners. The priorities are aligned with the local improvement work and we welcome the plan for commissioners to work closely with the Trust, we will continue to visit the hospitals and participate in the "go see" reviews of the work you are undertaking. This

is a welcome demonstration of your willingness to be transparent.

As last year the account could be further strengthened by the inclusion of narrative around the difficulties the Trust continues to experience in recruitment and retention of both medical and nursing staff.
The CCGs will of course continue to support you over the coming year in achieving the quality improvement priorities set out in the account.

Response from HealthWatch in Kirklees and Calderdale

HealthWatch in Kirklees and Calderdale continues to have an open, constructive relationship with CHFT. From working to understand the impact of Electronic Patient Records, to supporting people wanting to make complaints against the hospital, our relationship is always based on transparency and mutual trust. We look forward to continuing this relationship in 2018/19".

Rory Deighton Director HealthWatch Kirklees
Helen Wright, HealthWatch Calderdale

Response from the Governors to CHFT Quality Accounts 2017-2018:

The Council of Governors is pleased that the Trust continues to strive to provide high quality care, as detailed in its Quality Account. The Governors were given the opportunity to develop and select the key quality indicators for 2018/19 which were then put out to the wider membership for final selection. During 2017/18 Governors have been informed of the progress being made against the quality priorities for the year through formal reports to the Council of Governors meetings and discussions at Governors workshops and development sessions.. Governors sit on Divisional Reference Groups where they discuss patient safety and quality with the divisional management teams and undertake walkarounds in clinical areas. Governors have representation on the Patient Experience and Caring Group which looks at patient experience, engagement and equality and Governors have also taken part in PLACE inspections of both hospital sites.

All of this enables us to see at first hand the challenges of maintaining quality at a high level on an enduring basis. In addition, Governors have regular meetings with both Executive and Non-Executive Directors formally at Council of Governor meetings and more informally. Governors also attend, in an observer role, Board of Directors meetings and committee meetings, particularly the Quality Committee which has delegated responsibility and oversight of the Trust's progress towards achieving the quality priorities.

The Council of Governors supports and endorses the Quality Account and the priorities selected for particular focus over the coming year.

Brian Moore
Lead Governor

Response from Calderdale Overview and Scrutiny Committee

Comments requested but none received as at 20 April 2018.

Response from the Kirklees Health and Social Care Scrutiny Panel
Re: Calderdale and Huddersfield NHS Foundation Trust Draft Quality Account 2017/18

Thank you for your email dated 4 April 2018 inviting comment from the Kirklees Health and Adult Social Care Panel on the draft 2017/18 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

Please note that due to the timing of the submission the Panel hasn't had the opportunity to have a full discussion at a panel meeting and this is reflected in the level of comments received which is summarised below:

"The Panel welcome the opportunity to comment but wish to highlight that due to the timing of the submission the Panel did not have an opportunity to include a discussion at a full panel meeting and unfortunately this has resulted in restrictions in the level of feedback and comments.

The Panel is pleased to see that the Trust remains in the top 10% of best performing Trusts for achieving the targets for emergency care despite the extreme pressures that the Trust has faced during the winter period.

The Panel note that the three priorities set for 2017/18 have all met with measurable indices of success. Achieving a 90% screening for pathogens is a notable achievement and when taken with the improvements in the process for the recognition and rapid treatment of sepsis the Panel believe this will help make the Trust a safer place to be treated than previously.

The Panel do however have a concern that the targets set through the Commissioning for Quality and Innovation payment framework were not all fully achieved and in particular the administering of antibiotic within an hour for sepsis.

The Panel welcome the strategies to improve and develop effective discharge planning although the Panel would have liked to have seen more detail on readmission rates within 28 days.

The Panel support the work being done by the Trust to learn from complaints and believe that this should be a continued area of focus. The Panel would also wish to see the Trust continue to develop an open and transparent approach to sharing with the public details of common areas of complaints and the measures being taken to address them.

The Panel note the three priorities for 2018/19 and are generally supportive of the areas that will be covered although it was felt that for both priority one (Care of the Acutely Ill Patient) and priority three (End of Life Care) it was not entirely clear what the outcomes are to be and how they will be measured.

The Panel note that the overall ratings for the Trust's responsiveness to the personal needs of patients as reported from the National Inpatient Survey were lower than previous years. The Panel is supportive of the Trust's intention to improve the rating although it's unclear what steps will be taken to do this.

The Panel is pleased that the Trust has introduced an Electronic Patient Record and recognise the considerable benefits that this can bring with the potential to improve all aspects of patient care.

The Panel do however note that the introduction of the new system did have an impact on some areas of the Trust's performance and hope that the Trust will take forward the learning from this project when managing the introduction of other types of new systems in the future.

The Panel note that as in previous years the Quality Account includes minimal information on the local plans to reconfigure healthcare in the hospital and community settings which continues to be of significant interest to the Panel and local residents.

The performance of the Trust remains a high priority area for the Panel and is committed to continue to work closely with the Trust with the aim of ensuring that patients are receiving safe and effective services.

The Panel is also mindful of the significant financial challenges that the Trust faces in the coming years. The Panel intend to maintain a focus during 2018/19 on the work being developed locally by the Trust and the wider health and social care sector to increase efficiencies with the aim of ensuring that there is no adverse impact on the accessibility, quality and safety of patient services for the residents of Kirklees.

Yours sincerely,
Richard Dunne
Principal Governance and Democratic Engagement Officer
On behalf of the Kirklees Health and Adult Social Care Scrutiny Panel

Response from South West Yorkshire Partnership NHS Foundation Trust

As a partner of the Trust, we were pleased to receive and be asked to comment on the Calderdale and Huddersfield NHS Foundation Trust (CHFT) draft Quality Account for 2017/18.

The Quality Account provides an assessment of the levels of quality provided by the Trust, describing the progress made in many areas together with comparisons against other organisations. It was good to note the positive progress in achieving the three improvement priorities for 2017/18; sepsis screening, discharge planning and learning from complaints.

We welcomed the priorities for 2018/19 which focus on care of the acutely ill patient and improving outcomes through recognition, response and prevention of deteriorating patients; managing complex discharges and improving the experience of those patients who are being managed at the end of life.

We recognise the efforts by the Trust to address the areas in the CQC inspection, where CHFT was rated as good for caring and responsive but rated as "requires improvement" overall. The most recent CQC inspection has just taken place and we note that CHFT are awaiting the results of this.

We acknowledge the efforts of CHFT in response to a particularly challenging winter period. Despite the challenges and demands placed on services, we note the resilience and the professionalism shown by all staff resulting in CHFT being in the top performing 10% of NHS Trusts for emergency care.

We continue to work closely with CHFT on shared sites and in response to issues and challenges that arise where close collaboration provides mutual benefits for the users of our respective services, carers and staff.

As a provider organisation we welcome CHFT's commitment to working to ensure joined up services with partners and we look forward to working with CHFT in the future for the benefit of our local communities.

Yours sincerely
Tim Breedon
Director of Nursing & Quality
South West Yorkshire Partnership NHS Foundation Trust.

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 to prepare Quality Accounts for each financial year.

NHS Improvement 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 NHS 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 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - board minutes and papers for the period April 2017 to May 2017
  - papers relating to Quality reported to the board over the period April 2017 to May 2018
  - CQC inspection report dated August 2016
  - feedback from commissioners dated 20 April 2018
  - feedback from governors dated 20 April 2018
  - feedback from local HealthWatch organisations dated 5 April 2018
  - feedback from Kirklees Overview and Scrutiny Committee dated 18 April 2018
  - feedback from South West Yorkshire Partnership Foundation Trust date 10 May 2018
  - the Trust's complaints report for 2017/18 published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009
  - the 2016 Adult inpatient survey May 2017
  - the 2017 national staff survey March 2018
  - the Head of Internal Audit's annual opinion over the Trust's control environment dated 23 May 2018.

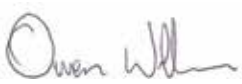
Feedback was requested from Calderdale Overview and Scrutiny Committee, Trust and Locala on 4 April 2018 but had not been received by 23 May 2018.

- 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 NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.
-

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

.....Chairman



..... Chief Executive

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

We have been engaged by the Council of Governors of Calderdale & Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale & Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;

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 NHS Improvement.

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 and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2017/18 ('the Guidance'); 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 Requirements for external assurance for quality reports for foundation trusts 2017/18.

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

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

- Board minutes and papers for the period April 2017 to May 2018;
- papers relating to quality reported to the board over the period April 2017 to May 2018;
- feedback from commissioners, dated 20 April 2018;
- feedback from governors, dated 20 April 2018;
- feedback from local Healthwatch organisations, dated 5 April 2018;
- feedback from Kirklees Overview and Scrutiny Committee, dated 18 April 2018;
- feedback from South West Yorkshire Partnership Foundation Trust date 10 May 2018;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2016 national adult patient survey, dated May 2018;
- the 2017 national staff survey, dated March 2018;
- Care Quality Commission Inspection, dated August 2018;
- the 2017/18 Head of Internal Audit's annual opinion over the trust's control environment, dated 23 May 2018; and
- any other information included in our review.

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 & Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting the 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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 & Huddersfield NHS Foundation Trust for our work or this report, except 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 indicator;
- 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; and
- 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 affect 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 of these criteria, 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 and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Calderdale & Huddersfield NHS Foundation Trust.

Basis for qualified conclusion

The Trust has included a statement in the Quality Report that it does not report the number of deaths of patients aged 0-18 which were more likely than not, to have been due to problems in the care provided. This information is only reported for deaths of adult patients. The reported information is therefore not in compliance with the requirements of the Detailed Requirements for Quality Reports 2017/18 issued by NHS Improvement.

With regard to the 'A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge' indicator, our testing identified that there was a discrepancy between the number of arrivals at A&E included in the report derived from the Trust system and those reported through the year by the Trust. The total discrepancy of case numbers was 768.

With regard to the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' indicator our testing identified that the Trust's processes were not accurately identifying the correct pathways. We identified cases which had been included in the calculation of the indicator which were not pathways. In addition the Trust undertakes a validation process for this data, this is a targeted methodology to ensure the Trust achieves the required performance and may not cover the total population in any one month.

As a result we are not able to conclude that nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018, the 'A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge', and 'the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' indicators have been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

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

KPMG LLP
Chartered Accountants
1 Sovereign Square
Leeds
LS1 4DA
24 May 2018

Appendix A: 2017/18 Clinical Audit

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in/participated in for which data collection was completed during 2017/18, are listed below. The numbers 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) are also listed.

Women's and Children's Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Child health programme (CHR-UK)	No	NA	NA	NA
Diabetes in pregnancy audit 2017	Yes	Yes	100%	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	417	100%
Paediatric intensive care (PICANet)	No	NA	NA	NA
RCEM Pain in children 2017	Yes	Yes	All cases in time period	100%

Acute

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%	On-going
National Joint Registry (NJR)	Yes	Yes	1087	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	143	100%
RCEM Procedural sedation 2017	Yes	Yes	All cases in time period	100%

Blood and transplant

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:				
2017 Re- Audit of Red Cell & Platelet transfusion in adult haematology patients	Yes	Yes	30	100%

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	Yes	235	100%
Lung cancer (NLCA)	Yes	Yes	303	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	All cases in time period	100%
National Prostate Cancer Audit	Yes	Yes	283	100%

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	901	100%
Adult cardiac surgery audit (ACS)	No	N/A	N/A	N/A
Cardiac arrhythmia (HRM)	Yes	Yes	100%	On-going
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	N/A	N/A
Coronary angioplasty (NICOR)	Yes	Yes	100%	On-going
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	151YTD	on-going
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	324	100%

Long term conditions

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	105	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD) Registry**	Yes	No	On-going	None
Renal replacement therapy (Renal Registry)	No	N/A	N/A	N/A
National Complicated Diverticulitis Audit (CAD)	Yes	Yes	On-going	All cases
National Ophthalmology Audit	Yes	Yes	2864	100%
RCP National COPD secondary care audit 2017	Yes	Yes	On–going	All cases

Mental Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Prescribing observatory for Mental Health(POMH-UK)	No	N/A	-	-

Older People

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Sentinel Stroke (SSNAP)	Yes	Yes	All	On-going
National audit of Dementia 2016-17 (round 3)	Yes	Yes	94	100%
RCEM Fracture Neck of Femur 2017	Yes	Yes		

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Specialist Rehab for patients with complex needs	No	N/A	-	-
UK Cystic Fibrosis Registry	No	N/A	-	-
Learning Disability Mortality Review (LeDeR)	Yes	Yes	10	100%
Elective surgery (National PROMs Programme)				
Groin hernia	Yes	Yes	All	On-going
Hip replacements	Yes	Yes	All	On-going
Knee replacements	Yes	Yes	All	On-going
Varicose veins	Yes	Yes	All	On-going

National Confidential Enquiries (NCEPOD)

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:				
Young Peoples Mental Health	Yes	Yes	3	75%
Chronic Neurodisability	Yes	Yes	2	100%
Cancer in Children, teens and young adult study (0-25 years)	Yes	No patients met the audit criteria		
Heart Failure Study	Yes	Yes	5	50%
Peri-operative Diabetes Study	Yes	Yes	Ongoing	Data collecting

The Trust did not take part in three national audits as detailed below.

Name of audit	Reason
Inflammatory bowel disease (IBD) Registry	Lack of resources
National audit information about the content of the delirium screen and delirium assessment – part of NAD audit	Not able to take part due to pressures of reconfiguration.
National Bariatric Surgery Registry	Awaiting response from lead, regarding subscriptions
BAUS Nephrectomy Surgery	Lack of resources
BAUS PCNL	Lack of resources

The reports of 39 national clinical audits were reviewed by the provider in 2017/18 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

National audit of Rheumatoid arthritis & early inflammatory arthritis (final / 2nd year results) 2015- 2016

The National Clinical Audit of Rheumatoid and Early Inflammatory Arthritis is part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP), overseen by the Healthcare Quality Improvement Partnership (HQIP). NCAPOP is a closely linked set of centrally-funded national clinical audit projects that collect data on compliance with evidence based standards and provide local Trusts with benchmarked reports on compliance and performance.

The HQIP funded project will provide a national comparative audit of the assessment, management and outcomes of adults presenting with rheumatoid and early inflammatory arthritis in all NHS secondary care settings in England and Wales where the service is provided. The audit is being designed so that results help clinicians improve the quality of care for patients and control their joint inflammation.

The National Institute for Health and Clinical Excellence (NICE) has drawn up seven key quality standards (Quality Standard 33) that are evidence-based and identify the most important goals for us to meet in delivering high quality care to our patients.

Patients aged 16 and over who presented for the first time in rheumatology departments were recruited where early inflammatory arthritis was suspected, following an assessment within the clinic. This included patients with:

- Rheumatoid arthritis
- Psoriatic arthritis
- Spondyloarthropathy with peripheral arthritis
- Undifferentiated arthritis

Data were collected at presentation to NHS rheumatology services and for the first 3 months of subsequent follow up appointments. Care received by these patients was assessed against the NICE Quality Standards for Rheumatoid Arthritis (QS33)1 and patient reported measures of experience and outcome, including data on ability to work. Data were also collected on the staffing and service models of each rheumatology service to explore the relationships between performance and organisational factors.

Data presented in this report are for patients recruited from 1 February 2015 to 30 October 2015. Recruitment was shortened to a 9-month period to ensure the analysis could be completed before the end of the contract. 97% of NHS rheumatology providers in England and Wales were registered to participate in the 2nd year of the audit and data from 5,002 patients were available. Over a 12 month period, this shows a 5% increase in patient recruitment. Overall, 11,356 patients were recruited in the two year data collection period, amounting to 38,311 records in total.

Aim:
- For patients the aim is that they will be more aware of their care and more able to take control of their personal health.

Objectives:
- To help transform the way that rheumatology is viewed and commissioned.
- To drive better access for patients and better care.

Summary of Findings:
The British Society for Rheumatology (BSR) 2nd and final report on the findings of the national audit for Rheumatoid & early inflammatory arthritis was published in July 2016.
The report covered data from Feb 2015 – Jan 2016.
They have stated that CHFT data submitted (i.e. case ascertainment) was not sufficient to provide robust benchmarking at trust level for this report.

What changes in practice have been agreed?
Actions from previous round are complete & embedded

Recommendation	Action	Lead Person	Timescale
Patients seen within 3 wks of referral	Triaging patients with inflammation into earlier clinics	Cheryl Fernandes	6 months to complete backlog of patients waiting to be seen, once we have substantive medical staff on board. - Sept 2016. **Now complete Sept 2017**
Achieving treatment target at follow up	Nurse training to document and act on disease activity	Julie Madden	6 months completing back log, nurse training. – Sept 2016. Now complete Sept 2017

National Paediatric Diabetes Audit 2015-16
The National Paediatric Diabetes Audit (NPDA) report highlights the main findings on the quality of care for children and young people with diabetes mellitus in England and Wales. Children and young people with diabetes have complex needs as they develop and grow, with a risk of complications or serious disease in later life. NPDA reports on markers that identify the risk of kidney, eye and cardiovascular disease, revealing hypertension in young people with Type 1 diabetes and an increase in obesity. An expanding partnership with the National Diabetes Audit (NDA) for adults is another way in which the NPDA is working to ensure that young diabetes patients receive more seamless diabetes care as they make the transition into adulthood. Diabetes is just one of many long-term conditions suffered by children and young people today, but with more cases of paediatric diabetes being reported year on year, the NPDA has never been more relevant.

The NPDA is a powerful tool for measuring performance, and reports on the delivery of a high quality system of care based on standards set by the National Institute for Health and Care Excellence (NICE). The audit specifically refers to the NICE clinical guideline CG15, Type 1 diabetes: Diagnosis and management of Type 1 diabetes in children, young people and adults, and enables commissioners to monitor progress against the national standards and identify gaps in care; helps families to benchmark local service quality and provides data to support PDUs and regional networks in the improvement of care across the UK.

The NICE CG15, states that all children and young people with diabetes over 12 years of age should receive seven key care processes in order to achieve optimum control over their disease and reduce the potential for serious health complications. The seven care processes include:

- HbA1c (all ages to receive this process)
- Height and weight
- Blood pressure
- Urinary albumin
- Cholesterol
- Eye screening
- Foot examination

The responsibility for addressing any inconsistencies and gaps in care which are failing many children, lies primarily with the PDUs, but also requires a coordinated effort from regional networks, commissioners, local authorities, families and other stakeholders to ensure the high standards are reached and variability in outcomes is reduced. Where PDUs show under-performance by these measures, Trusts/Health Boards and Commissioners are urged to work with regional networks to ensure that clinical data are captured in their entirety, and to facilitate the submission of the most complete and accurate dataset to better ensure appropriate representation of PDU outcomes.

Objectives:
The main objective of NPDA is to examine the quality of care for children and young people with diabetes mellitus in England and Wales.

Summary of findings for CHFT
A total of 229 children and young people were included in this audit.

Compared to audit 2014-15 our HbA1c has improved more than Y&H and E&W but is still an outlier and is an outlier in the percentage of patients with HbA1c <58mmol/mol.

Median

Year	CHFT	E&W
2014-15	74	66.5
2015-16	69.5	65

Proportionally greater reduction.

Adjusted mean

Year	CHFT	E&W
2014-15	78	70.6
2015-16	75.1	68.3

In 2014 our current Consultant for diabetes at CRH started as a locum, being the 4th Consultant covering the service at CRH in two years. This is unsettling for patients, parents and the Team. Since July 2015 Dr How Yaw has been appointed to the substantive post which has provided continuity and stability to the Team from a medical point of view. During 2015-16, Nancy one of our experienced PDSNs retired in the January and was not replaced until the July, Maria, another experienced PDSN, retired in the August and was not replaced until March 16. Both new PDSNs were new to the post and required a period of learning and development. Another experienced PDSN had a period of prolonged sick leave during the year as well, following surgery. The Team have been back up to full numbers since March 16 and hopefully this will be reflected in the next audit. Despite being at least one PDSN down for the year, the team did make improvements in the mean and median HbA1c during 2015-16.

The age distribution of patients in the CHFT children's diabetes service are similar to Y&H and E&W, except for the 5-9 age group where CHFT have more. The ethnicity of patients and the type of diabetes are the same across Y&H and E&W.

Care Processes
Percentage of patients with the care processes HbA1c, BP and albuminuria screening is the same across the 3 groups. Thyroid screening and BMI documentation is slightly reduced in CHFT compared to the other groups but eye screening and foot examination were significantly better in CHFT compared to Y&H and E&W.

The percentage of patients that have completed all 7 care processes, CHFT was in the middle of the funnel plot but no actual figure was given.

The percentage of patients screened for thyroid disease and coeliac disease within 90 days of diagnosis was much better at CHFT than Y&H and E&W.

Outcomes of care
Fewer patients at CHFT had HbA1cs <48, 53 and 58 mmol/mol than Y&H and E&W.
More patients at CHFT had HbA1cs >69, 75 and 80 mmol/mol than Y&H and E&W.
This is related to our higher adjusted mean and median HbA1cs.

The percentage of patients with an HbA1c >80mmol/mol has come down from 37.9% to 28.8% (and reduced in E&W down from 21.5% to 17.9%). CHFT was an outlier on this funnel plot but has now moved to the edge of the plot.

CHFT has significantly fewer patients with abnormal eye screening compared to Y&H and E&W and fewer patients with missing eye screening data, suggesting that this a real difference.

The percentage of patients with microalbuminuria is higher in CHFT than the other 2 groups and is higher than CHFT in 2014-15. This is not a difference that has been noted clinically and is therefore likely to be due to data entry.

Patient's BP, patients with hypertension, with high cholesterol and weights (underweight, overweight and Obese) are similar across the 3 groups.

Access to education is better in CHFT than Y&H and E&W. 'No psychology referral required' is significantly lower in CHFT and those referred to and seen by psychology are significantly higher in CHFT than the other groups and again this is likely to be a data entry error.

CHFT continues to have a higher percentage of patients with coeliac disease and diabetes than the rest of the country.

What changes in practice have been agreed?
KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Action plan lead	Name: Lynne Terrett	Title: Consultant	Contact: 2465 HRI

The 'Actions required' should specifically state what needs to be done to achieve the recommendation. All updates to the action plan should be included in the 'Comments' section.

Recommendation	**Actions required** (specify 'None', if none required)	**Action by date**	**Person responsible**	**Comments/action status** (Provide examples of action in progress, changes in practices, problems encountered in facilitating change, reasons why recommendation has not been actioned etc.)	**Change stage** (see Key)
Planned Time-Out for the whole team	To take place 21/07/17	21/07/17	Dr Lynne Terrett, Cons		2
To start high HbA1c clinic	Already discussed and arranged with clinic	December 2017	Dr Lynne Terrett, Cons; Jean Hayman, Lead Nurse	Already discussed and arranged with clinic, awaiting EPR to settle	2
Longer clinic appointments to 30 minutes, to provide more education and support.	Have 30 minute appointments to comply with peer review	October 17	Dr Lynne Terrett, Cons; Dr Steph How-Yaw, Cons; Gill Harris, General Manager	Spoken to Gill Harris	3
To present 6 monthly data to network and paeds forum	Ongoing	Ongoing throughout the year every 6 months	Alison Oversby, Paeds Dietitian	Embedded - Complete	3
To make IT data collection more accurate.	Team to meet monthly for a half day with Mandy, secretary, to support and improve accuracy of data entry. Continue to discuss with IT re: data collection from EPR and SystmOne to make it easier	Underway every month	Alison Oversby, Paeds Dietitian and Amanda Watson, Secretary	Underway	2
Psychology-facilitated clinics for patients with recurrent admissions	Trial of psychology facilitated clinics	November 2017	Amanda Gill, Paeds Psychologist		2
More education and activity days to support and educate young patients	Ongoing	March 2018	Jean Hayman, Lead Nurse		2
Focus on management in first 12 months after diagnosis, aiming for early normoglycaemia. Review of initial targets, meter settings etc.	Review at the Time-Out meeting to aim to set up good habits	21/11/17	All		2

Other National Clinical Audits the Trust has participated in during 2017/18:
- Breast & Cosmetic Implant Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Invasive cytology
- National Cardiac Rehab audit
- SAMBA 2017 (Against the Clock)
- BTS Bronchoscopy
- BSUG Stress Incontinence database
- National Completed Acute Diverticulitis Audit (CADS)
- OAKS (Outcomes after Kidney Injury)
- National Audit of Small Bowel Obstruction (NASBO)
- Potential Donor Audit
- Epistaxis Audit

The reports of 89 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Missed Small for Gestational Age audit
Babies who weigh <10th centile at birth are described as Small for Gestational Age (SGA) and have an increased risk of stillbirth or poor neonatal outcome. Risk assessment and surveillance for fetal growth restriction are part of the NHS Saving Babies' Lives Care Bundle.

Objectives:
- The number of babies <10th centile on the customised growth chart at birth
- The number of undetected small for gestation age babies <10th centile at birth
- Compliance with the CHFT guideline for the routine assessment of fetal growth

Summary of Findings:
To ensure all babies < 10th centile were included in this audit babies weighing ≤ 3000gms n = 321 were reviewed to capture babies not recorded as < 10th centile on Athena
- Number of babies < 10th centile n = 143
- Total births CHFT May – July 2017 n = 1399
- Incidence of babies < 10th centile 10.2%
- Number babies known to be SGA on scan n = 88
- Missed SGA n = 55
- Detection rate SGA 61%

Reasons for missed SGA
- Fundal height measurement/ centiles were higher than birth weight centiles, 20th – 95th centile. The fundal height measurement predicted a baby ≥ 50th centile 82% (14/17) women who had no scans.
- 69% (38/55) women with a missed SGA baby had growth scans in pregnancy. Staff were reassured by the estimated fetal weight centiles on scan 12th, to 95th centiles (≥ 50th centile n = 10 nearest to birth).
- One woman had five different sonographers performing the growth scans, the centiles from EFW were 95th, 30th, 30th, 10th and 40th.
- 4 Bradford women did not have a customised growth chart completed by their midwife

Summary
- Clinical documentation in Athena regarding birthweight centile < 10th centile is not accurate.
- The detection rate for known SGA < 10th centile May – July 2017 was 61%
- Women with a previous SGA baby 12/12, women who conceived following IVF 3/3, women who reported reduced fetal movements (RFM) 9/9 and women with a BMI ≥ 37 4/4 were offered growth scans following trust guidance

What changes in practice have been agreed?

Recommendations	Actions	Lead Person	Timescale
A business case to plot the Resistance Index with the scan instead of manually writing this on a paper form	A business case is being prepared	Kathy Kershaw, Midwife	January 2018

Audit of Senior Review of under 1yr olds (Infants) in the emergency department

Ideally those patients under 1 year of age (infants) should be seen by a senior member of the A&E team prior to discharge. This is a high risk group – particularly when presenting with bruise or injury in infants<6 months or in a non-mobile child.
Guidance should be followed regarding adequate care received by paediatric cases in the ED: Specific guidance regarding safeguarding children potentially at risk – often outlined in Local trust policy

Infants (Under 1yr Olds) are recognized as a group of patients who are at a higher risk level due to various reasons. Hence it is recommended that they be reviewed by a Senior Clinician. Last year's audit of practice showed that 25% of Infants were not offered this service. This group included Infants who were known to Social Services as well.
Senior Clinicians = ED Consultants, ED Registrars/MGs, Paediatric Consultants, Paediatric Registrars, Paediatric Advanced Nurse Practitioners.

Aim:
To review all children under 1 presenting to the A&E department from Sept 2015 – Aug 2016
Children discharged from A&E
Seen by senior (ENP, middle grade or above)
Presenting with burns, contusions, #
Discussed with paediatrics, Social Services/already known to services

Summary of Findings
EDIS notes reviewed for the following information:-
1) Documented ED senior as reviewing the patient in the department.
2) Children presenting with burns, contusions (inc head injury), #
3) Children d/w paediatrics
4) Children known to or referred to SS prior to d/c

Results
- Total included = 1373
- Number seen by Senior in A&E = 984 (72%)
- Burns/contusion (inc MHI), # = 208 (15%)
  ==> Of these 199 (96%) were seen by a senior
- D/W paeds rather than A&E senior = 106 (8%)
- Known to or d/w SS or support workers = 12 (0.9%)
  ==> 3(0.2%) infants known to SS were not seen by a senior
- 283(21%) neither seen by A&E senior nor d/w paeds

Conclusion
- 21% of children <1 discharged from ED were not seen by an A&E senior
- Of those infants presenting with burns, contusion or # 4% were not seen by a senior in the emergency department
- 25% of those infants either referred to or already known to SS were not seen by a senior in the department
- Noted from EDIS retrieval that some of these patients may have been seen but nothing was documented!

All infants presenting to our EDs are reviewed by a Senior Clinician before they are discharged. Junior colleagues are advised to discuss all infants with a senior.

It is highly recommended for seniors to review patients themselves in following presentations:
1. All with fever
2. All with PAWS score >4
3. All neonates (less than 28days old)
4. All known to social services (including any family member known to services)
5. All with burns
6. All with suspected skull fractures
7. All with long bone fractures (excluding elbow, wrist, knee & ankle fractures)
8. All non-mobile infants with injuries
9. Returning with same problem within 72hrs
10. Any concerning presentations

After review/ discussion, the encounter should be documented in EPR notes as a separate entry titled as "Senior Review". It's recommended to use "ED Senior Review Notes" for this purpose. This should be ideally done by the Senior Clinician; however, the Junior Clinician could do it on behalf of them. Senior should check that note and endorse it in an addendum with any corrections/ additions if needed.

What changes in practice have been agreed?

Recommendation	Action	Responsible Person	Target Date	Date Completion & Evidence
Ensure infants would not be streamed in to "Minors"	All current Triage trained nurses should be informed about this & add on to ongoing Triage Training	Ms Louise Croxall	15/08/2017	15/09/2017
Ensure all Junior Doctors & ANPs are informed that infants should be discussed with a Senior & document the encounter on EPR	Include in Junior Doctors & ANPs Induction. Expand 1 of 4 "Consultant sign-off" indications "Under 1yrs old with Fever" to "All Under 1Yr old" Reinforce through "Paediatric" talk at Induction	Dr Mark Davies Dr Chamika Mapatuna	03/08/2017	03/08/2017 Induction PP presentations
	Reinforce same information at Junior Doctors teaching session on "Safeguarding"	Dr Chamika Mapatuna Ms Janet Youd	28/09/2017	28/09/2017 Teaching PP presentation
	Reinforce same information at ANP teaching	Dr Huw Masson	15/08/2017	15/09/2018
Ensure all ED Senior Clinicians are informed that they should give a "Senior Sign-Off" to all infants by direct review or through case discussion with documented evidence on EPR	Memo to all ED Consultants, Registrars/ MG Trust Doctors, regular MG Locums & Senior Paediatric Doctors and PNPs (via Dr Cath Rouke ED Link Paediatric Consultant)	Dr Chamika Mapatuna	15/08/2017	15/09/2017 Memo
Re-audit the process	Audit in April 2018 – Review randomly selected 100 (50 from each site) case notes of Infants presented between Oct 2017 to March 2018	Dr Chamika Mapatuna	15/04/2018	01/06/2018 Present at June QI Forum

Use of opioids in palliative care – NICE CG140 snapshot

Pain is common in advanced and progressive disease. Up to two-thirds of people with cancer experience pain that needs a strong opioid. This proportion is similar or higher in many other advanced and progressive conditions.

Despite the increased availability of strong opioids, published evidence suggests that pain which results from advanced disease, especially cancer, remains under-treated.

Each year 300,000 people are diagnosed with cancer in the UK and it is estimated that there are 900,000 people living with heart failure. Others live with chronic illness such as kidney, liver and respiratory disease, and with neurodegenerative conditions. Many people with these conditions will develop pain for which a strong opioid may be needed.

Strong opioids, especially morphine, are the principal treatments for pain related to advanced and progressive disease, and their use has increased significantly in the primary care setting. However, the pharmacokinetics of the various opioids are very different and there are marked differences in bioavailability, metabolism and response among patients.

A suitable opioid must be selected for each patient and, because drug doses cannot be estimated or calculated in advance, the dose must be individually titrated. Effective and safe titration of opioids has a major impact on patient comfort.

Objectives:

- To ascertain if prescriptions are appropriate
- Do patients understand what they are prescribed & the side effects →Communication
- To review compliance (should hit 100%)

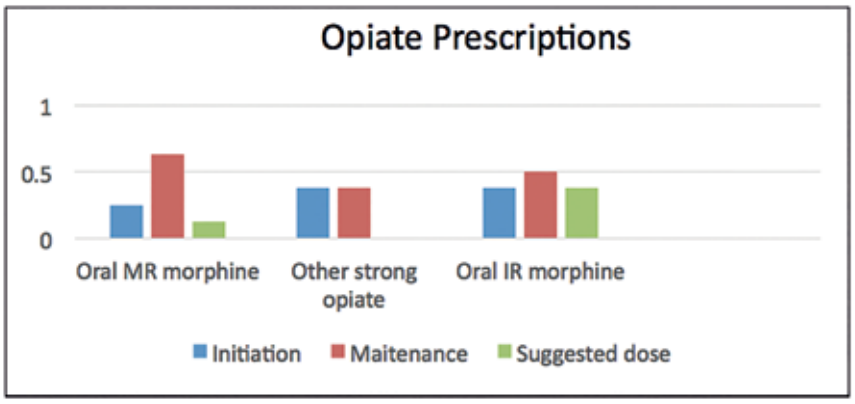
Summary of findings for CHFT

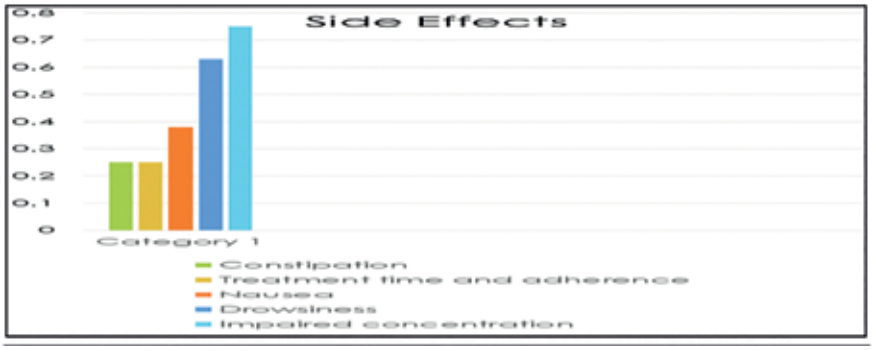
The ward 12 book was used to review current inpatients with admissions over the last four months.

Discharge summaries were also reviewed.

8 patients only – difficult to find on EPR.

Difficult to go back more than 4 months as some patients had died, some at end of life or didn't meet criteria so were not included. Some patients were started on opiates by GP.





Conclusions

- Limitations included:
- Sample number small
- Finding the information challenging
- Patient life span reduced
- Refusal or inappropriate to fill questionnaire
- Opiates prescribed in other settings
- Anticipatory prescribing
- Failing to prescribed laxatives
- Not reaching NICE standards

Discussion

- A leaflet re morphine is already available on the repository. Beware of information overload for patients and also of morphine addiction /overload / side effects.
- A significant number (almost 40%, of a small number) were prescribed other strong opioids, ?oxycodone. The guidance is clear that the first line opioid should be morphine, so when a re-audit is undertaken, we need to look at much bigger numbers, and also look for evidence as to why morphine wasn't prescribed, or why oxycodone was.
- It would also be good to look at prescribing in renal impairment (which isn't mentioned in NICE guidance, but is hugely important).
- Look and see if the guidance on the Trust intranet (and which echoes regional guidance in Y&H) is being adhered to.
- Also review anticipatory medicine prescribing, which can easily be accessed through EPR. There is a suspicion that the PRN doses are often incorrect for patients already prescribed strong opioids.

Recommendations

- Leaflets, TTOS →patients. Encourage patients to ask questions in consultations
- Re-audit with larger number. Re-audit to include:
  o evidence as to why morphine wasn't prescribed, or why oxycodone was.
  o prescribing in renal impairment
  o if the guidance on the Trust intranet (and which echoes regional guidance in Y&H) is being adhered to.
  o review of anticipatory medicine prescribing to ascertain if the PRN doses are correct for patients already prescribed strong opioids.

What changes in practice have been agreed?

KEY (Change status)
1 Recommendation agreed but not yet actioned
2 Action in progress
3 Recommendation fully implemented
4 Recommendation never actioned (please state reasons)
5 Other (please provide supporting information)

Action plan lead	Name: Mary Kiely	Title: Palliative Care Consultant	Contact: x2965 HRI

Recommendation	**Actions required** (specify 'None', if none required)	**Action by date**	**Lead Person**	**Comments/action status** (i.e. action in progress, changes in practices, problems facilitating change, reasons why recs have not been actioned etc.)	**Change stage** (see Key)
Improve communication with patients : i.e. leaflets &, TTOS	Encourage patients to ask questions in consultations	Ongoing	All medical staff		2
Re-audit with larger numbers & points listed above for more robust results	Add to 2018/19 OHPC audit programme	April 2018	Junior doctors to be nominated by MK		1

NHS

Calderdale and Huddersfield

NHS Foundation Trust

Accounts 2017/18

compassionate care

Calderdale & Huddersfield NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Foreword to the accounts
Calderdale & Huddersfield NHS Foundation Trust

These accounts, for the year ended 31 March 2018, have been prepared by Calderdale & Huddersfield NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Owen Williams (Chief Executive)
Date: 23rd May 2018

STATEMENT OF COMPREHENSIVE INCOME				
		2017/18		**2016/17**
	Note	**£000**		**£000**
Operating income from patient care activities	3	321,058		330,970
*Other operating income	4	39,413		44,281
Operating expenses	6, 8	(395,953)		(374,838)
Operating surplus/(deficit) from continuing operations		**(35,482)**		**413**
Finance income	11	43		34
Finance expenses	12	(12,584)		(11,937)
PDC dividends payable		(1,449)		(2,488)
Net finance costs		**(13,990)**		**(14,391)**
Other gains / (losses)	13	-		(236)
Share of profit / (losses) of associates / joint arrangements	19	868		423
Gains / (losses) arising from transfers by absorption		-		-
Corporation tax expense		-		-
Surplus / (deficit) for the year from continuing operations		**(48,604)**		**(13,791)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14			-
****Surplus / (deficit) for the year**		**(48,604)**		**(13,791)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	7	(7,658)		(5,754)
Revaluations	18	9,869		8,523
Share of comprehensive income from associates and joint ventures	19	-		-
Other recognised gains and losses		-		-
Other reserve movements		-		-
***Capital Goods Scheme adjustment		1,476		
May be reclassified to income and expenditure when certain conditions are met:				
Fair value gains / (losses) on available-for-sale financial investments	13	-		-
Recycling gains / (losses) on available-for-sale financial investments	13	-		-
Foreign exchange gains / (losses) recognised directly in OCI	13	-		-
Total comprehensive income / (expense) for the period		**(44,917)**		**(11,022)**

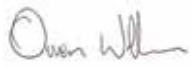
* Other operating income includes £5.584m of Sustainability and Transformation Fund income, (16/17 £12.654m).

** The surplus / (deficit) for 17/18 includes £18.655m impairments; for 16/17 this was £1.204m reversal of impairment.

***Capital Goods Scheme adjustment in relation to the set up of a wholly owned subsidiary company, see note 1.3.

STATEMENT OF FINANCIAL POSITION			
		31 March 2018	**31 March 2017**
	Note	**£000**	**£000**
Non-current assets			
Intangible assets	15	7,410	1,866
Property, plant and equipment	16	219,734	234,272
Investments in associates and joint ventures	19	3,757	2,889
Trade and other receivables	22	3,525	3,130
Total non-current assets		**234,426**	**242,157**
Current assets			
Inventories	21	6,836	6,724
Trade and other receivables	22	23,052	19,298
Non-current assets held for sale / assets in disposal groups	23	1,798	4,215
Cash and cash equivalents	24	2,000	1,941
Total current assets		**33,686**	**32,178**
Current liabilities			
Trade and other payables	25	(41,066)	(41,536)
Borrowings	27	(17,266)	(4,053)
Provisions	28	(1,188)	(1,878)
Other liabilities	26	(1,296)	(1,552)
Total current liabilities		**(60,816)**	**(49,019)**
Total assets less current liabilities		**207,295**	**225,316**
Non-current liabilities			
Trade and other payables	25	(100)	(164)
Borrowings	27	(162,601)	(135,214)
Provisions	28	(2,014)	(2,306)
Other liabilities	26	(1,204)	(1,339)
Total non-current liabilities		**(165,919)**	**(139,023)**
Total assets employed		**41,376**	**86,292**
Financed by			
Public dividend capital		116,190	116,190
Revaluation reserve		39,310	37,464
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(114,124)	(67,362)
Total taxpayers' equity		**41,376**	**86,292**

The Financial Statements were approved by the Board on 23 May 2018 and signed on its behalf by:



Name
Owen Williams
Position
Chief Executive
Date
23 May 2018

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018				
	Public dividend capital	**Revaluation reserve**	**Income and expenditure reserve**	**Total**
	£000	**£000**	**£000**	**£000**
Taxpayers' equity at 1 April 2017 - brought forward	**116,190**	**37,464**	**(67,362)**	**86,292**
Surplus/(deficit) for the year	-	-	(48,604)	**(48,604)**
Other transfers between reserves	-	(365)	365	**0**
Impairments	-	(7,658)	-	**(7,658)**
Revaluations	-	9,869	-	**9,869**
Capital Goods Scheme adjustment			1,476	**1,476**
Taxpayers' equity at 31 March 2018	**116,190**	**39,310**	**(114,124)**	**41,376**

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2017				
	Public dividend capital	**Revaluation reserve**	**Income and expenditure reserve**	**Total**
	£000	**£000**	**£000**	**£000**
Taxpayers' equity at 1 April 2016 - brought forward	**115,720**	**36,121**	**(54,998)**	**96,843**
Surplus/(deficit) for the year	-	-	(13,791)	**(13,791)**
Other transfers between reserves	-	(557)	557	**-**
Impairments	-	(5,754)	-	**(5,754)**
Revaluations	-	8,523	-	**8,523**
Transfer to retained earnings on disposal of assets	-	(869)	869	**-**
Public dividend capital received	470	-	-	**470**
Taxpayers' equity at 31 March 2017	**116,190**	**37,464**	**(67,362)**	**86,292**

Information on reserves

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 organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

STATEMENT OF CASH FLOWS				
		2017/18		**2016/17**
	Note	**£000**		**£000**
Cash flows from operating activities				
Operating surplus / (deficit)		(35,482)		413
Non-cash income and expense:				
Depreciation and amortisation	6.1	10,584		10,074
Net impairments	7	18,655		(1,204)
Income recognised in respect of capital donations	4	(75)		(66)
(Increase) / decrease in receivables and other assets		(2,643)		(3,222)
(Increase) / decrease in inventories		(112)		248
Increase / (decrease) in payables and other liabilties		3,679		(3,714)
Increase / (decrease) in provisions		(984)		(528)
Tax (paid) / received		-		-
Operating cash flows from discontinued operations		-		-
Other movements in operating cash flows		(14)		8
Net cash generated from / (used in) operating activities		**(6,392)**		**2,009**
Cash flows from investing activities				
Interest received		43		34
Purchase and sale of financial assets / investments		-		-
Purchase of intangible assets		(430)		(998)
Sales of intangible assets		-		-
Purchase of property, plant, equipment and investment property		(20,021)		(17,200)
Sales of property, plant, equipment and investment property		-		1,348
Receipt of cash donations to purchase capital assets		75		66
Prepayment of PFI capital contributions		-		-
Investing cash flows of discontinued operations		-		-
Cash movement from acquisitions/disposals of subsidiaries		-		-
Net cash generated from / (used in) investing activities		**(20,333)**		**(16,750)**
Cash flows from financing activities				
Public dividend capital received		-		470
Public dividend capital repaid		-		-
Movement on loans from the Department of Health and Social Care		42,082		29,827
Movement on other loans		-		-
Other capital receipts		-		-
Capital element of finance lease rental payments		-		-
Capital element of PFI, LIFT and other service concession payments		(1,483)		(1,405)
Interest paid on finance lease liabilities		-		-
Interest paid on PFI, LIFT and other service concession obligations		(11,092)		(10,850)
Other interest paid		(1,245)		(944)
PDC dividend (paid) / refunded		(1,479)		(2,354)
Financing cash flows of discontinued operations		-		-
Cash flows from (used in) other financing activities		-		-
Net cash generated from / (used in) financing activities		**26,783**		**14,744**
Increase / (decrease) in cash and cash equivalents		**59**		**3**
Cash and cash equivalents at 1 April - brought forward		**1,941**		**1,938**
Cash and cash equivalents at 31 March	**24.1**	**2,000**		**1,941**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 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.

Note 1.2 Going concern
The accounting concept of Going Concern refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. If an organisation is a going concern, it is expected to operate indefinitely and not go out of business or liquidate its assets in the foreseeable future.
Under International Financial Reporting Standards, management are required to assess, as part of the accounts process, the NHS Foundation Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of services to another entity, or has no realistic alternative but to do so.
The Trust Board has assessed various sources of information in order to determine whether it is appropriate to prepare the accounts on a going concern basis. These include both internal and external reporting, the Trust's long term financial plan, audit reports and dialogue with NHS Improvement.
The Trust has closed the year with a cash balance of £2.0m and positive net assets of £41.3m.
However, given the deficit position and the challenge within the financial plans for 2018/19 further areas require consideration to be able to demonstrate that the Trust is a going concern.
The following has been taken into account when going concern is considered:
The year-end financial position of £29.9m deficit (excluding impairments as described in note to the SOCI) was in line with the deficit discussed and agreed with the regulator in year. Whilst still a deficit position; this secures a level of confidence from NHS Improvement in the Trust's financial management.
The Trust is supported by loan funding from the Department of Health and Social Care with a balance totalling £103.9m at 31 March 2018.
The Trust closed the year with £2.0m of cash but cannot sustain the planned deficit position within 2018/19 without the requirements of external cash support.
As such, the Trust has been in communication with NHS Improvement to arrange for loan facilities to enable the Trust to operate throughout 2018/19. Approval and drawdown of this cash funding from the Department of Health and Social Care will take place on a rolling monthly basis. With this borrowing in place, the Trust will be able to meet its liabilities.
The Commissioners continue to commission services from the Trust and contracts with commissioners have been agreed and were signed in April 2018. This leads to regular monthly transfers of fixed levels of cash based on contracted values for 2018/19. This incoming cash along with the loan facility will allow the Trust to meet all its obligations and liabilities.
From Internal Audit reports completed in 2017/18 there have been no other indications of significant financial risk or weaknesses in financial risk management.
The Trust is continuing to work upon a service transformation strategy working closely with local partners, aided by reconfiguration, to deliver a sustainable long term future. This strategy has been supported by regulators.
In 2017/18 a cost improvement programme (CIP) of £17.9m was delivered. A project management office is in place and ensures that the CIP plans for 2018/19 are robust and oversees their delivery. The programme methodology is built around a gateway approach for project design, development and delivery that includes a rigorous quality and equality impact assessment review. Delivery of the 2018/19 planned deficit position requires an efficiency saving of a further £18m.
The matters, referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.
However, there is a reasonable expectation that Calderdale & Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.

Note 1.3 Interests in other entities
Joint ventures
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Subsidiaries
Calderdale & Huddersfield NHS Foundation Trust is the corporate trustee to Calderdale & Huddersfield NHS Foundation Trust charitable fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The Foundation Trust has assessed that the values involved are not of material nature and the Trust Board has approved and agreed not to consolidate the Charitable Funds.

During 17/18 the foundation trust created a wholly owned subsidiary company "Calderdale And Huddersfield Solutions Ltd". The purpose of the company is to provide a Managed Healthcare Facility to the foundation trust.

Note 1.4 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 health care services. At the year end, the trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where income is received for a specific activity which is to be delivered in a subsequent 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.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit."

Note 1.5 Expenditure on employee benefits
Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees.

Pension costs
NHS Pension Scheme
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. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes.

Employer's 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.

Note 1.6 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.

Note 1.7 Property, plant and equipment
Note 1.7.1 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
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 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 year - During the financial year the foundation trust created a subsidiary company "Calderdale And Huddersfield Solutions Ltd". The purpose of the company is to provide a Managed Healthcare Facility to the foundation trust, a consequence of this was that VAT became recoverable under an MEA, on the same basis the PFI site is valued.

A full valuation was last carried out in March 2015.

A desktop revaluation exercise was carried out of all property as at 31 March 2018.

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

Specialised operational property is valued using the HM Treasury standard approach of depreciated replacement cost valuation based on modern equivalent assets and where it would meet the location requirement of the service being provided on 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.

Equipment is carried at depreciated historical cost as this is considered to be a reasonable proxy for fair value

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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 GAM, impairments that arise from a clear consumption of economic benefits or of 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 that arises from a clear consumption of economic benefit or of 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 expenditure 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 to the income and expenditure reserve, an amount is transferred back to 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.

Note 1.7.3 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 ie:

    - 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."

Note 1.7.4 Donated and grant funded assets
"Donated and grant funded property, plant and equipment assets are capitalised at 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 been met.

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
PFI and LIFT 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. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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.

Note 1.7.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Min life	**Max life**
	Years	**Years**
Land	-	-
Buildings, excluding dwellings	15	80
Dwellings	15	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 1.8.1 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, eg, 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, eg 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, eg application software, is capitalised as an intangible asset."

Note 1.8.2 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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.

Note 1.8.3 Useful economic lives of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Min life	Max life
	Years	Years
Information technology	5	5
Development expenditure	-	-
Websites	-	-
Software licences	5	8
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 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.

Note 1.10 Cash and cash equivalents
Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the entity's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.11 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 to 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 above/below.

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

De-recognition
All financial assets are de-recognised when the rights to receive cash flows 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.

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

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

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

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts 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 cash flows 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.

Note 1.12 Leases
Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.12.1 The trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 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
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

Note 1.12.2 The trust as lessor
Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.13 Provisions
The 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
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 28.2 but is not recognised in the trust's accounts.

Non-clinical risk pooling
The 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 NHS Resolution 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.

Note 1.14 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 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, 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.

Note 1.15 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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 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 (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (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 the audit of the annual accounts."

Note 1.16 Value added tax
Most of the activities of the 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.

Note 1.17 Corporation tax
The Foundation 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 Foundation Trust has assessed that it is not liable to pay corporation tax.

Note 1.18 Foreign exchange
The functional and presentational currency of the trust is 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."

Note 1.19 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the 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 FReM.

Note 1.20 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 the trust 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 1.21 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.22 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted
The Treasury FReM does not require the following Standards and Interpretations to be applied in 2017-18. The application of the Standards as revised would not have a material impact on the accounts for 2017-18, were they applied in that year:
IFRS 9 Financial Instruments
IFRS 15 Revenue from Contracts with Customers

Note 2 Operating Segments
The Foundation Trust's core activities fall under the remit of the Chief Operating Decision Maker ("CODM") as defined by IFRS 8 'Operating Segments', which has been determined to be the Foundatrion Trust Board which includes senior professional non-executive directors. These core activities are primarily the provision of specialist NHS healthcare, the income for which is received through contracts with commissioners. The planned level of activity is agreed with our main commissioners for the year, and are listed in the related party disclosures (see Note 35)

Healthcare
The large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore a segment of 'Healthcare' is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board. The Trust Board reviews the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a distinct operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers this segment of healthcare in its decision-making process.

	Healthcare	
	2017/18	**2016/17**
	£000	**£000**
Income	**360,471**	**375,251**
Surplus / (Deficit)	**(48,604)**	**(13,791)**
Net Assets	**41,376**	**86,292**

NOTE 3 OPERATING INCOME FROM PATIENT CARE ACTIVITIES			
Note 3.1 Income from patient care activities (by nature)	**2017/18**		**2016/17**
	£000		**£000**
Acute services			
Elective income	42,071		49,190
Non elective income	100,284		89,725
First outpatient income	17,412		20,774
Follow up outpatient income	18,800		25,148
A & E income	17,020		16,996
High cost drugs income from commissioners (excluding pass-through costs)	73		62
* Other NHS clinical income	96,519		95,077
Community services			
Community services income from CCGs and NHS England	23,285		23,137
Income from other sources (e.g. local authorities)	-		-
All services			
Private patient income	647		474
*Other clinical income	4,948		10,388
Total income from activities	**321,058**		**330,970**

* Other NHS Clinical Income and Other Clinical Income includes income for NHS Tariff income including income for, Direct access £6.0m and maternity pathways £10.3m, it also includes Non Tariff income including income for, block contracts of £28.7m for various services, including community services, income for critical care £7.3m, pass through cost for high cost drugs and devices £24.4m, rehabilitation £4.2m, diagnostic tests and imaging £7.6m, CQUIN £6.7m, local priced outpatients £5.1m and other clinical income of £1.167m.

NOTE 3.2 INCOME FROM PATIENT CARE ACTIVITIES (BY SOURCE)			
Income from patient care activities received from:	**2017/18**		**2016/17**
	£000		**£000**
NHS England	27,821		30,779
Clinical commissioning groups	285,079		288,159
Department of Health and Social Care	-		-
Other NHS providers	809		1,212
NHS other	-		-
Local authorities	3,086		6,057
Non-NHS: private patients	647		474
Non-NHS: overseas patients (chargeable to patient)	100		118
NHS injury scheme	1,789		1,910
Non NHS: other	1,727		2,261
Total income from activities	**321,058**		**330,970**
Of which:			
Related to continuing operations	321,058		330,970
Related to discontinued operations	-		-

NOTE 3.3 OVERSEAS VISITORS (RELATING TO PATIENTS CHARGED DIRECTLY BY THE PROVIDER)			
	2017/18		**2016/17**
	£000		**£000**
Income recognised this year	100		118
Cash payments received in-year	28		26
Amounts added to provision for impairment of receivables	53		120
Amounts written off in-year	-		11

NOTE 4 OTHER OPERATING INCOME			
	2017/18		**2016/17**
	£000		**£000**
Research and development	979		1,074
Education and training	9,076		8,790
Receipt of capital grants and donations	75		66
Charitable and other contributions to expenditure	387		425
*Non-patient care services to other bodies	9,412		9,028
Support from the Department of Health and Social Care for mergers	-		-
Sustainability and transformation fund income	5,584		12,654
Rental revenue from operating leases	58		58
Rental revenue from finance leases	-		-
Income in respect of staff costs where accounted on gross basis	-		-
**Other income	13,842		12,186
Total other operating income	**39,413**		**44,281**
Of which:			
Related to continuing operations	39,413		44,281
Related to discontinued operations	-		-

* Non-patient care services to other bodies includes £5.1m income for The Health Informatics Service, for IT services provided to other bodies and £3.1m income for Estates and Facilities for recharges to other bodies for use of buildings, including £3m to SWYPFT for use of the Dales unit.

** Other operating income of £13.842m includes £9.5m sales of manufactured pharmaceutical products, £1.9m car parking income, £0.4m property rental income, £0.6m catering income (In 2016/17 the comparative figures were £7.3m for sale of manufactured in pharmaceutical products, £2.7m car parking income, £0.5m property rental income, £0.4m catering income).

NOTE 4.1 INCOME FROM ACTIVITIES ARISING FROM COMMISSIONER REQUESTED SERVICES			
Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:			
	2017/18		**2016/17**
	£000		**£000**
Income from services designated as commissioner requested services	313,130		324,121
Income from services not designated as commissioner requested services	7,928		6,849
Total	**321,058**		**330,970**

NOTE 4.2 PROFITS AND LOSSES ON DISPOSAL OF PROPERTY, PLANT AND EQUIPMENT			
The Trust made no disposals in year.			

NOTE 5 FEES AND CHARGES
The Trust doesn't have Income from fees and charges levied by the trust where the full cost exceeds £1 million

NOTE 6.1 OPERATING EXPENSES			
	2017/18		**2016/17**
	£000		**£000**
Purchase of healthcare from NHS and DHSC bodies	2,491		1,928
Purchase of healthcare from non-NHS and non-DHSC bodies	1,477		818
Purchase of social care	-		-
Staff and executive directors costs	244,943		240,908
Remuneration of non-executive directors	163		163
Supplies and services - clinical (excluding drugs costs)	26,448		31,170
Supplies and services - general	2,618		3,259
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	35,132		32,916
Inventories written down	-		-
Consultancy costs	145		61
Establishment	4,292		4,394
Premises	16,751		14,857
Transport (including patient travel)	436		488
Depreciation on property, plant and equipment	10,157		9,810
Amortisation on intangible assets	427		264
Net impairments	18,655		(1,204)
Increase/(decrease) in provision for impairment of receivables	(21)		76
Increase/(decrease) in other provisions	(565)		(211)
Change in provisions discount rate(s)	(1)		164
Audit fees payable to the external auditor			
audit services- statutory audit	55		55
other auditor remuneration (external auditor only)	12		12
Internal audit costs	139		182
Clinical negligence	17,042		15,493
Legal fees	126		149
Insurance	-		-
Research and development	8		18
Education and training	757		727
Rentals under operating leases	4,032		4,548
Early retirements	-		-
Redundancy	28		171
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	8,210		12,027
Charges to operating expenditure for off-SoFP IFRIC 12 schemes	-		-
Car parking & security	-		-
Hospitality	29		18
Losses, ex gratia & special payments	-		6
Grossing up consortium arrangements	-		-
Other services, eg external payroll	-		-
Other	1,967		1,570
Total	**395,953**		**374,838**
Of which:			
Related to continuing operations	395,953		374,838
Related to discontinued operations	-		-

NOTE 6.2 OTHER AUDITOR REMUNERATION			
	2017/18		**2016/17**
	£000		**£000**
Other auditor remuneration paid to the external auditor:			
1. Audit of accounts of any associate of the trust	-		-
2. Audit-related assurance services	12		12
3. Taxation compliance services	-		-
4. All taxation advisory services not falling within item 3 above	-		-
5. Internal audit services	-		-
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. Other non-audit services not falling within items 2 to 7 above	-		-
Total	**12**		**12**

Note 6.3 Limitation on auditor's liability
There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

NOTE 7 IMPAIRMENT OF ASSETS			
	2017/18		**2016/17**
	£000		**£000**
Net impairments charged to operating surplus / deficit resulting from:			
Loss or damage from normal operations	-		-
Over specification of assets	-		-
Abandonment of assets in course of construction	-		-
Unforeseen obsolescence	-		-
Loss as a result of catastrophe	-		-
Changes in market price	18,655		(1,204)
Other	-		-
Total net impairments charged to operating surplus / deficit	**18,655**		**(1,204)**
Impairments charged to the revaluation reserve	7,658		5,754
Total net impairments	**26,313**		**4,550**

The impairments and reversal of impairments charged to operating costs and the revaluation reserve are due to changes in market values. £9.496m relates to Land Buildings and Dwellings.

£14.400m relates to the impairment of the Electronic Patient Record System, to the market value for the remaining life of the contract.

£2.417m relates to Assets Held For Sale - St Lukes Hospital land, to reflect its current market value.

NOTE 8 EMPLOYEE BENEFITS			
	2017/18		**2016/17**
	Total		**Total**
	£000		£000
Salaries and wages	189,114		180,742
Social security costs	17,515		16,594
Apprenticeship levy	915		-
Employer's contributions to NHS pensions	22,893		22,087
Pension cost - other	16		-
Other post employment benefits	-		-
Other employment benefits	-		-
Termination benefits	-		-
Temporary staff (including agency)	17,005		23,439
Total gross staff costs	**247,458**		**242,862**
Recoveries in respect of seconded staff	-		-
Total staff costs	**247,458**		**242,862**
Of which			
Costs capitalised as part of assets	2,515		1,954

NOTE 8.1 RETIREMENTS DUE TO ILL-HEALTH
During 2017/18 there were 3 early retirements from the trust agreed on the grounds of ill-health (11 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £178k (£735k in 2016/17). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 9.1 Other Pension costs

The Foundation Trust offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST) for those staff ineligible to contribute to the NHS Pension.

The cost to the Foundation Trust of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

NOTE 10 OPERATING LEASES

NOTE 10.1 CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST AS A LESSOR

This note discloses income generated in operating lease agreements where Calderdale & Huddersfield NHS Foundation Trust is the lessor.

The lease revenue is for property leased to other organisations

	2017/18		2016/17
	£000		£000
Operating lease revenue			
Minimum lease receipts	53		52
Contingent rent	5		6
Other	-		-
Total	**58**		**58**

	31 March 2018		31 March 2017
	£000		£000
Future minimum lease receipts due:			
- not later than one year;	48		43
- later than one year and not later than five years;	34		32
- later than five years.	10		8
Total	**92**		**83**

NOTE 10.2 CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST AS A LESSEE

This note discloses costs and commitments incurred in operating lease arrangements where Calderdale & Huddersfield NHS Foundation Trust is the lessee.

	2017/18		2016/17
	£000		£000
Operating lease expense			
Minimum lease payments	4,041		4,558
Contingent rents	-		-
Less sublease payments received	(9)		(10)
Total	**4,032**		**4,548**

	31 March 2018		31 March 2017
	£000		£000
Future minimum lease payments due:			
- not later than one year;	3,268		3,254
- later than one year and not later than five years;	8,781		9,023
- later than five years.	18,182		19,727
Total	**30,231**		**32,004**
Future minimum sublease payments to be received	(44)		-

Of the operating lease expenditure £1.9m is for the leasing of buildings (£1.7m 16/17), £2.1m is for the leasing of plant and machinery (£2.29m 16/17)

NOTE 11 FINANCE INCOME			
Finance income represents interest received on assets and investments in the period.			
	2017/18		**2016/17**
	£000		**£000**
Interest on bank accounts	43		34
Interest on impaired financial assets	-		-
Interest income on finance leases	-		-
Interest on other investments / financial assets	-		-
Other finance income			-
Total	**43**		**34**

NOTE 12.1 FINANCE EXPENDITURE			
Finance expenditure represents interest and other charges involved in the borrowing of money.			
	2017/18		**2016/17**
	£000		**£000**
Interest expense:			
Loans from the Department of Health and Social Care	1,480		1,051
Other loans	-		-
Overdrafts	-		-
Finance leases	-		-
Interest on late payment of commercial debt	10		-
Main finance costs on PFI and LIFT schemes obligations	6,596		6,715
Contingent finance costs on PFI and LIFT scheme obligations	4,496		4,135
Total interest expense	**12,582**		**11,901**
Unwinding of discount on provisions	2		36
Other finance costs	-		-
Total finance costs	**12,584**		**11,937**

NOTE 12.2 THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998 / PUBLIC CONTRACT REGULATIONS 2015
The Trust incurred costs of £10k during 17/18 (£336 - 16/17) arising from claims made under this legislation.

NOTE 13 OTHER GAINS / (LOSSES)			
	2017/18		**2016/17**
	£000		**£000**
Gains on disposal of assets	-		-
Losses on disposal of assets	-		(236)
Total gains / (losses) on disposal of assets	-		(236)
Total other gains / (losses)	**-**		**(236)**

NOTE 14 DISCONTINUED OPERATIONS
The Trust had no discontinued operations to disclose in 2017/18 or 2016/17.

NOTE 15.1 INTANGIBLE ASSETS - 2017/18			
	Software licences	**Internally generated information technology**	**Total**
	£000	**£000**	**£000**
Valuation / gross cost at 1 April 2017 - brought forward	**636**	**3,107**	**3,743**
Transfers by absorption	-	-	-
Additions	73	357	430
Impairments	-	(14,400)	(14,400)
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications (from Tangible PPE Assets under construction (Note 16.1))	-	19,941	19,941
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Gross cost at 31 March 2018	**709**	**9,005**	**9,714**
Amortisation at 1 April 2017 - brought forward	**632**	**1,245**	**1,877**
Transfers by absorption	-	-	-
Provided during the year	2	425	427
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to / from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2018	**634**	**1,670**	**2,304**
Net book value at 31 March 2018	**75**	**7,335**	**7,410**
Net book value at 1 April 2017	**4**	**1,862**	**1,866**

NOTE 15.2 INTANGIBLE ASSETS - 2016/17			
	Software licences	**Internally generated information technology**	**Total**
	£000	**£000**	**£000**
Valuation / gross cost at 1 April 2016 - as previously stated	**636**	**2,109**	**2,745**
Prior period adjustments	-	-	-
Valuation / gross cost at 1 April 2016 - restated	**636**	**2,109**	**2,745**
Transfers by absorption	-	-	-
Additions	-	998	998
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Valuation / gross cost at 31 March 2017	**636**	**3,107**	**3,743**
Amortisation at 1 April 2016 - as previously stated	**593**	**1,020**	**1,613**
Prior period adjustments	-	-	-
Amortisation at 1 April 2016 - restated	**593**	**1,020**	**1,613**
Transfers by absorption	-	-	-
Provided during the year	39	225	264
Impairments	-	-	-
Reversals of impairments	-	-	-
Revaluations	-	-	-
Reclassifications	-	-	-
Transfers to/ from assets held for sale	-	-	-
Disposals / derecognition	-	-	-
Amortisation at 31 March 2017	**632**	**1,245**	**1,877**
Net book value at 31 March 2017	**4**	**1,862**	**1,866**
Net book value at 1 April 2016	**43**	**1,089**	**1,132**

NOTE 16.1 PROPERTY, PLANT AND EQUIPMENT - 2017/18									
	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Valuation/gross cost at 1 April 2017 - brought forward	**32,766**	**157,761**	**1,914**	**14,988**	**28,927**	**70**	**37,050**	**1,924**	**275,400**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	5,451	-	5,392	2,976	-	1,368	-	**15,187**
Impairments	(775)	(14,534)	(177)	-	-	-	-	-	**(15,486)**
Reversals of impairments	-	5,990	-	-	-	-	-	-	**5,990**
Revaluations	-	4,654	78	-	-	-	-	-	**4,732**
Reclassifications	-	-	-	(19,941)	-	-	-	-	**(19,941)**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Valuation/gross cost at 31 March 2018	**31,991**	**159,322**	**1,815**	**439**	**31,903**	**70**	**38,418**	**1,924**	**265,882**
Accumulated depreciation at 1 April 2017 - brought forward	**-**	**-**	**-**	**-**	**20,610**	**42**	**18,925**	**1,551**	**41,128**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,102	35	-	1,492	6	3,471	51	**10,157**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(5,102)	(35)	-	-	-	-	-	**(5,137)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**22,102**	**48**	**22,396**	**1,602**	**46,148**
Net book value at 31 March 2018	**31,991**	**159,322**	**1,815**	**439**	**9,801**	**22**	**16,022**	**322**	**219,734**
Net book value at 1 April 2017	**32,766**	**157,761**	**1,914**	**14,988**	**8,317**	**28**	**18,125**	**373**	**234,272**

NOTE 16.2 PROPERTY, PLANT AND EQUIPMENT - 2016/17									
	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Valuation / gross cost at 1 April 2016 - as previously stated	**32,766**	**150,428**	**1,853**	**7,523**	**26,440**	**70**	**32,841**	**1,901**	**253,822**
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation / gross cost at 1 April 2016 - restated	**32,766**	**150,428**	**1,853**	**7,523**	**26,440**	**70**	**32,841**	**1,901**	**253,822**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	8,086	-	8,040	2,707	-	4,241	23	**23,097**
Impairments	-	(7,201)	(38)	-	-	-	-	-	**(7,239)**
Reversals of impairments	-	2,689	-	-	-	-	-	-	**2,689**
Revaluations	-	3,184	99	-	-	-	-	-	**3,283**
Reclassifications	-	575	-	(575)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(220)	-	(32)	-	**(252)**
Valuation/gross cost at 31 March 2017	**32,766**	**157,761**	**1,914**	**14,988**	**28,927**	**70**	**37,050**	**1,924**	**275,400**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**-**	**-**	**-**	**19,327**	**36**	**15,941**	**1,503**	**36,807**
Prior period adjustments	-	-	-	-	-	-	-	-	**-**
Accumulated depreciation at 1 April 2016 - restated	**-**	**-**	**-**	**-**	**19,327**	**36**	**15,941**	**1,503**	**36,807**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	5,202	38	-	1,500	6	3,016	48	**9,810**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(5,202)	(38)	-	-	-	-	-	**(5,240)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	(217)	-	(32)	-	**(249)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**20,610**	**42**	**18,925**	**1,551**	**41,128**
Net book value at 31 March 2017	**32,766**	**157,761**	**1,914**	**14,988**	**8,317**	**28**	**18,125**	**373**	**234,272**
Net book value at 1 April 2016	**32,766**	**150,428**	**1,853**	**7,523**	**7,113**	**34**	**16,900**	**398**	**217,015**

NOTE 16.3 PROPERTY, PLANT AND EQUIPMENT FINANCING - 2017/18									
	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Net book value at 31 March 2018									
Owned - purchased	31,485	79,558	1,815	439	9,630	22	15,980	322	**139,251**
Finance leased	506	-	-	-	-	-	-	-	**506**
On-SoFP PFI contracts and other service concession arrangements	-	79,443	-	-	-	-	-	-	**79,443**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	321	-	-	171	-	42	-	**534**
NBV total at 31 March 2018	**31,991**	**159,322**	**1,815**	**439**	**9,801**	**22**	**16,022**	**322**	**219,734**

NOTE 16.4 PROPERTY, PLANT AND EQUIPMENT FINANCING - 2016/17									
	Land	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant & machinery**	**Transport equipment**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Net book value at 31 March 2017									
Owned - purchased	32,250	84,201	1,914	14,988	8,167	28	18,067	373	**159,988**
Finance leased	516	-	-	-	-	-	-	-	**516**
On-SoFP PFI contracts and other service concession arrangements	-	72,590	-	-	-	-	-	-	**72,590**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	-	-	**-**
Owned - donated	-	970	-	-	150	-	58	-	**1,178**
NBV total at 31 March 2017	**32,766**	**157,761**	**1,914**	**14,988**	**8,317**	**28**	**18,125**	**373**	**234,272**

Note 17 Donations of property, plant and equipment
During 17/18 the Trust received cash from Calderdale & Huddersfield Charitable Funds of £75k (£66k 16/17), for items of equipment to be purchased which included: an additional Ultrasound Scanners for Radiology and ENT and a Sherlock System for Peripherally Inserted Central Catheters for the Medical Division.

Note 18 Revaluations of property, plant and equipment
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 year. During the financial year the foundation trust created a subsidiary company ""Calderdale And Huddersfield Solutions Ltd"". The purpose of the company is to provide a Managed Healthcare Facility to the foundation trust. A consequence of this was that VAT became recoverable under an MEA, on the same basis the PFI site is valued. Where applicable the valuations exclude VAT.
A full valuation was last carried out in March 2015.
A desktop revaluation was carried out of all property 31 March 2018.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Charted Surveyors (RICS) Appraisal and Valuation Manual.
Specialised operational property is valued using the HM Treasury standard approach of depreciated replacement cost valuation based on modern equivalent assets, and where it would meet the location requirement of the service being provided on 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

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Note 19 Investments in associates and joint ventures

	2017/18		2016/17
	£000		£000
Carrying value at 1 April - brought forward	**2,889**		**2,466**
Transfers by absorption	-		-
Acquisitions in year	-		-
Share of profit / (loss)	868		423
Impairments	-		-
Reversal of impairment	-		-
Transfers to / from assets held for sale and assets in disposal groups	-		-
Disbursements / dividends received	-		-
Disposals	-		-
Share of Other Comprehensive Income recognised by joint ventures / associates	-		-
Other equity movements (translation gains / losses)	-		-
Carrying value at 31 March	**3,757**		**423**

NOTE 20 DISCLOSURE OF INTERESTS IN OTHER ENTITIES

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This partnership is the Pennine Property Partnership LLP (PPP LLP)and is owned 50/50 by the Trust and Henry Boot Development Ltd.

It has developed 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 has involved the substantial reconstruction and refurbishment of an existing derelict stone mill, known as Acre Mill, and now provides a range of modern outpatient facilities. The facility has been in use since the end of January 2015.

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	**2017/18**		**2016/17 (restated)**
	£000		£000
Non current assets	13,879		12,374
Current assets	607		1,172
Total assets	**14,486**		**13,546**
Current liabilities	(223)		(327)
Non current liabilities	(6,600)		(6,600)
Total liabilities	**(6,823)**		**(6,927)**
Net Assets Attributable to members	**7,663**		**6,619**
Operating income	666		675
Operating expenses	(312)		(234)
Fair Value revaluation Gain	1,506		375
Surplus /(deficit) for the year	**1,860**		**816**

* The March 2017 numbers have been restated to reflect the audited accounts of PPP LLP, Total assets was restated from £13.637m to £13.546m and also to restate the total liabilities from £12.597m to £6.927 as the Net assets attributable to members had been included in Non current liabilities incorrectly, the surplus for the year was restated from £941k to £816k.

During 17/18 the foundation trust created a wholly owned subsidiary company "Calderdale And Huddersfield Solutions Ltd". The purpose of the company is to provide a Managed Healthcare Facility to the foundation trust.

NOTE 21 INVENTORIES			
	31 March 2018		**31 March 2017**
	£000		**£000**
Drugs	2,370		2,336
Work In progress	310		370
Consumables	4,156		4,018
Energy	-		-
Other	-		-
Total inventories	**6,836**		**6,724**
of which:			
Held at fair value less costs to sell	-		-
Inventories recognised in expenses , including write-down of inventoriesfor the year were £61,606k (2016/17: £64,218k).			

NOTE 22.1 TRADE RECEIVABLES AND OTHER RECEIVABLES			
	31 March 2018		**31 March 2017**
	£000		**£000**
Current			
Trade receivables	12,092		7,223
Capital receivables (including accrued capital related income)	79		78
Accrued income	6,779		5,952
Provision for impaired receivables	(999)		(1,036)
Deposits and advances	-		-
Prepayments (non-PFI)	1,707		2,255
PFI prepayments - capital contributions	-		-
PFI lifecycle prepayments	-		-
Interest receivable	-		-
Finance lease receivables	-		-
PDC dividend receivable	131		101
VAT receivable	1,331		966
Corporation and other taxes receivable	-		-
Other receivables	1,932		3,759
Total current trade and other receivables	**23,052**		**19,298**
Non-current			
Trade receivables	-		-
Capital receivables (including accrued capital related income)	1,595		1,675
Accrued income	700		-
Provision for impaired receivables	-		-
Deposits and advances	-		-
Prepayments (non-PFI)	-		-
PFI prepayments - capital contributions	-		-
PFI lifecycle prepayments	-		-
Interest receivable	-		-
Finance lease receivables	-		-
VAT receivable	-		-
Corporation and other taxes receivable	-		-
Other receivables	1,230		1,455
Total non-current trade and other receivables	**3,525**		**3,130**
Of which receivables from NHS and DHSC group bodies:			
Current	11,472		12,974
Non-current	-		-

NOTE 22.2 PROVISION FOR IMPAIRMENT OF RECEIVABLES		
	2017/18	**2016/17**
	£000	**£000**
At 1 April as previously stated	**1,036**	**1,281**
Prior period adjustments	-	-
At 1 April - restated	**1,036**	**1,281**
Transfers by absorption	-	-
Increase in provision		98
Amounts utilised	(16)	(321)
Unused amounts reversed	(21)	(22)
At 31 March	**999**	**1,036**

NOTE 22.3 CREDIT QUALITY OF FINANCIAL ASSETS				
	31 March 2018		**31 March 2017**	
	Trade and other receivables	**Investments & Other financial assets**	**Trade and other receivables**	**Investments & Other financial assets**
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	-	-
90- 180 days	260	-	183	-
Over 180 days	739	-	853	-
Total	**999**	**-**	**1,036**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	6,232	-	2,560	-
30-60 Days	836	-	1,483	-
60-90 days	75	-	773	-
90- 180 days	433	-	388	-
Over 180 days	918	-	536	-
Total	**8,494**	**-**	**5,740**	**-**

NOTE 23 NON-CURRENT ASSETS HELD FOR SALE AND ASSETS IN DISPOSAL GROUPS			
	2017/18		**2016/17**
	£000		**£000**
NBV of non-current assets for sale and assets in disposal groups at 1 April	**4,215**		**5,783**
Prior period adjustment			-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	**4,215**		**5,783**
Transfers by absorption	-		-
Assets classified as available for sale in the year	-		-
Assets sold in year	-		(1,568)
Impairment of assets held for sale	(2,417)		-
Reversal of impairment of assets held for sale	-		-
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	**1,798**		**4,215**

The assets classified as held for sale as at 31 March 2018, were two assets of land and buildings namely the St Luke's Hospital site (SLH) and The Poplars nursery building.

"A property disposal review was completed in 2015 which identified 38 Acre Street, The Poplars and Princess Royal Health Centre as surplus to requirements. At 31st March 2017, sales had been completed for Princess Royal and 38 Acre Street. The Poplars sale had been agreed with the current occupants of the building and the sale is expected to complete during 18/19.

At the Board of Directors in January 2016 it was agreed to transfer the St Luke's Hospital (SLH) site to the Pennine Property Partnership (PPP) in line with the agreement in place on the establishment of the PPP 24th March 2011. The transfer is expected to complete in 2018. The value of SLH has been impaired in 17/18 to reflect the current market valuation."

NOTE 24.1 CASH AND CASH EQUIVALENTS MOVEMENTS			
Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.			
	2017/18		**2016/17**
	£000		**£000**
At 1 April	**1,941**		**1,938**
Net change in year	59		3
At 31 March	**2,000**		**1,941**
Broken down into:			
Cash at commercial banks and in hand	42		65
Cash with the Government Banking Service	1,958		1,876
Deposits with the National Loan Fund	-		-
Other current investments	-		-
Total cash and cash equivalents as in SoFP	**2,000**		**1,941**
Bank overdrafts (GBS and commercial banks)	-		-
Drawdown in committed facility	-		-
Total cash and cash equivalents as in SoCF	**2,000**		**1,941**

NOTE 24.2 THIRD PARTY ASSETS HELD BY THE TRUST			
Calderdale & Huddersfield NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.			
	31 March 2018		**31 March 2017**
	£000		**£000**
Bank balances	2		2
Monies on deposit	7		7
Total third party assets	**9**		**9**

Note 25 Trade and other payables				
		31 March 2018		**31 March 2017**
		£000		**£000**
Current				
Trade payables		15,155		13,903
Capital payables		4,777		9,611
Accruals		12,382		10,882
Receipts in advance (including payments on account)		-		-
Social security costs		-		-
VAT payables		-		-
Other taxes payable		4,736		4,442
PDC dividend payable		-		-
Accrued interest on loans		492		262
Other payables		3,525		2,436
Total current trade and other payables		**41,066**		**41,536**
Non-current				
Trade payables		-		-
Capital payables		-		-
Accruals		-		-
Receipts in advance (including payments on account)		-		-
VAT payables		-		-
Other taxes payable		-		-
Other payables		100		164
Total non-current trade and other payables		**100**		**164**
Of which payables from NHS and DHSC group bodies:				
Current		5,273		1,438
Non-current		-		-

NOTE 26 OTHER LIABILITIES			
	31 March 2018		**31 March 2017**
	£000		£000
Current			
Deferred income	1,296		1,552
Deferred grants	-		-
PFI deferred income / credits	-		-
Lease incentives	-		-
Total other current liabilities	**1,296**		**1,552**
Non-current			
Deferred income	1,204		1,339
Deferred grants	-		-
PFI deferred income / credits	-		-
Lease incentives	-		-
Net pension scheme liability	-		-
Total other non-current liabilities	**1,204**		**1,339**

NOTE 27 BORROWINGS			
	31 March 2018		**31 March 2017**
	£000		**£000**
Current			
Bank overdrafts	-		-
Drawdown in committed facility	-		-
Loans from the Department of Health and Social Care	15,658		2,571
Other loans	-		-
Obligations under finance leases	-		-
PFI lifecycle replacement received in advance	-		-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,608		1,482
Total current borrowings	**17,266**		**4,053**
Non-current			
Loans from the Department of Health and Social Care	88,202		59,206
Other loans	-		-
Obligations under finance leases	-		-
PFI lifecycle replacement received in advance	-		-
Obligations under PFI, LIFT or other service concession contracts	74,399		76,008
Total non-current borrowings	**162,601**		**135,214**

NOTE 28.1 PROVISIONS FOR LIABILITIES AND CHARGES ANALYSIS

	Pensions - early departure costs	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**1,180**	**144**	**355**	**2,506**	**4,184**
Transfers by absorption	-	-	-	-	-
Change in the discount rate	(1)	-	-	-	(1)
Arising during the year	22	107	-	818	946
Utilised during the year	(253)	(66)	-	(99)	(418)
Reclassified to liabilities held in disposal groups	-	-	-	-	-
Reversed unused	(15)	(39)	(195)	(1,263)	(1,512)
Unwinding of discount	1	-	-	0	2
At 31 March 2018	**934**	**146**	**160**	**1,962**	**3,202**
Expected timing of cash flows:					
- not later than one year;	222	146	160	660	1,188
- later than one year and not later than five years;	515	-	-	530	1,045
- later than five years.	197	0	0	772	969
Total	**934**	**146**	**160**	**1,962**	**3,202**

* Other provision of £1.962m includes £1.2m Injury Benefit.

NOTE 28.2 CLINICAL NEGLIGENCE LIABILITIES

At 31 March 2018, £188,463k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Calderdale & Huddersfield NHS Foundation Trust (31 March 2017: £188,216k).

NOTE 29 CONTINGENT ASSETS AND LIABILITIES

The Trust is pursuing a claim with NHS Resolution for compensation against costs incurred as a result of damage to endoscopy equipment in a fire, the outstanding value of the claim is a contingent asset worth up to £0.5m at 31 March 2018 (Nil as At 31st March 2017)
There were no contingent liabilities to disclose at 31 March 2018 or 31 March 2017.

NOTE 30 CONTRACTUAL CAPITAL COMMITMENTS

	31 March 2018		31 March 2017
	£000		£000
Property, plant and equipment	2,229		6,052
Intangible assets	-		-
Total	**2,229**		**6,052**

NOTE 31 OTHER FINANCIAL COMMITMENTS

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements), analysed by the period during which the payment is made:

	31 March 2018		31 March 2017
	£000		£000
not later than 1 year	2,495		2,373
after 1 year and not later than 5 years	7,485		10,186
paid thereafter	7,328		7,324
Total	**17,308**		**19,883**

This commitment relates to a contract with Cerner Ltd to deliver an Electronic Patient Record system and includes costs relating to Bradford Teaching Hospital NHS Foundation Trust. The contractual commitment remains with Calderdale & Huddersfield NHS Foundation Trust as the contract signatory.

Calderdale & Huddersfield NHS Foundation Trust has a back to back legal agreement with Bradford Teaching Hospital NHS Foundation Trust to idemnify Calderdale and Huddersfield NHS Foundation Trust against any associated risk.

NOTE 32 ON-SOFP PFI, LIFT OR OTHER SERVICE CONCESSION ARRANGEMENTS

The Trust has a PFI scheme for Calderdale Royal Hospital. The PFI contractor is Calderdale Hospitals SPC Ltd (formerly Catalyst Healthcare Ltd). The Trust is responsible for the provision of all clinical services, Calderdale Hospitals SPC Ltd provide fully serviced hospital accommodation.

NOTE 32.1 IMPUTED FINANCE LEASE OBLIGATIONS

Calderdale & Huddersfield NHS Foundation Trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2018		31 March 2017
	£000		£000
Gross PFI, LIFT or other service concession liabilities	**259,179**		**264,063**
Of which liabilities are due			
- not later than one year;	13,065		12,436
- later than one year and not later than five years;	58,492		53,736
- later than five years.	187,622		197,891
Finance charges allocated to future periods	(183,172)		(186,573)
Net PFI, LIFT or other service concession arrangement obligation	**76,007**		**77,490**
- not later than one year;	1,608		1,482
- later than one year and not later than five years;	10,037		8,162
- later than five years.	64,362		67,846

NOTE 32.2 TOTAL ON-SOFP PFI, LIFT AND OTHER SERVICE CONCESSION ARRANGEMENT COMMITMENTS

Total future obligations under these on-SoFP schemes are as follows:

	31 March 2018		31 March 2017
	£000		£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	450,693		463,582
Of which liabilities are due:			
- not later than one year;	27,501		26,167
- later than one year and not later than five years;	115,615		110,005
- later than five years.	307,577		327,410

NOTE 32.3 ANALYSIS OF AMOUNTS PAYABLE TO SERVICE CONCESSION OPERATOR

This note provides an analysis of the trust's payments in 2017/18:

	2017/18		2016/17
	£000		£000
Unitary payment payable to service concession operator	**22,315**		**25,712**
Consisting of:			
- Interest charge	6,596		6,715
- Repayment of finance lease liability	1,483		1,405
*- Service element and other charges to operating expenditure	7,534		11,381
- Capital lifecycle maintenance	1,530		1,430
- Revenue lifecycle maintenance	676		646
- Contingent rent	4,496		4,135
- Addition to lifecycle prepayment	-		-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-		-
Total amount paid to service concession operator	**22,315**		**25,712**

* The reduction in year is due to a negotiated non-recurrent refund of PFI facilities management costs for past events.

Note 33 Financial instruments

Note 33.1 Financial risk management

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust neither buys or sells financial instruments. The NHS Foundation Trust has limited powers to invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Board of Directors has approved a Treasury Management policy which sets out the parameters for investing any surplus operating cash in short-term deposits. This includes the restriction of any such investment to permitted institutions with appropriate credit ratings; these ratings are in line with the guidance issued by Monitor 'Managing Operating Cash in NHS Foundation Trusts'. In addition the policy sets out the maximum limits for any such investments and the Trust's approach to borrowing. 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 currently held financial liabilities carry nil or fixed rates of interest. The Trust therefore currently has low exposure to interest rate fluctuations. Future borrowing is planned to be provided by the Department of Health.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives cash each month based on an annually agreed level of contract activity with regular in-year adjustments to reflect actual levels of income due.

To finance the Trust's deficit position the Trust required loan funding in 2017/18 as was the case in 2016/17. The drawdown of revenue borrowing totalled £38.1m in 2017/18 and was secured from Department of Health in the form of an Interim Revenue Support Facility at an interest rate of 1.5%.

In 2017/18 the Trust has financed part of its capital expenditure from internally generated funds with the balance of £8m funded from a Capital loan from Department of Health at 2.35%.

The Trust's 2018/19 plan recognises that the Trust will require cash support from the Department of Health of £43.1m which will be drawn down on a monthly basis, The Trust is therefore, not 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 33.2 CARRYING VALUES OF FINANCIAL ASSETS

	Loans and receivables	Assets at fair value through the I&E	Held to maturity at	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	19,821	-	-	-	19,821
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	2,000	-	-	-	2,000
Total at 31 March 2018	**21,821**	**-**	**-**	**-**	**21,821**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets *	15,572	-	-	-	15,572
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,941	-	-	-	1,941
Total at 31 March 2017	**17,513**	**-**	**-**	**-**	**17,513**

*The March 17 figure has been restated from £9.620m to £15.572m to include £5.74m of acccrued income which had been excluded in the March 17 balance.

NOTE 33.3 CARRYING VALUE OF FINANCIAL LIABILITIES

	Other financial liabilities		Liabilities at fair value through the I&E		Total book value
	£000		£000		£000
Liabilities as per SoFP as at 31 March 2018					
Embedded derivatives	-		-		-
Borrowings excluding finance lease and PFI liabilities	103,860		-		103,860
Obligations under finance leases	-		-		-
Obligations under PFI, LIFT and other service concession contracts	76,007		-		76,007
Trade and other payables excluding non financial liabilities	36,431		-		36,431
Other financial liabilities	-		-		-
Provisions under contract	-		-		-
Total at 31 March 2018	**216,298**		**-**		**216,298**

	Other financial liabilities		Liabilities at fair value through the I&E		Total book value
	£000		£000		£000
Liabilities as per SoFP as at 31 March 2017					
Embedded derivatives	-		-		-
Borrowings excluding finance lease and PFI liabilities	61,777		-		61,777
Obligations under finance leases	-		-		-
Obligations under PFI, LIFT and other service concession contracts	77,490		-		77,490
Trade and other payables excluding non financial liabilities	37,094		-		37,094
Other financial liabilities	-		-		-
Provisions under contract	-		-		-
Total at 31 March 2017	**176,361**		**-**		**176,361**

NOTE 33.4 FAIR VALUES OF FINANCIAL ASSETS AND LIABILITIES

The book value (carrying value of financial assets and liabilities is a reasonable approximation of fair value.

NOTE 33.5 MATURITY OF FINANCIAL LIABILITIES

	31 March 2018		31 March 2017
	£000		£000
In one year or less	50,581		41,148
In more than one year but not more than two years	30,804		16,629
In more than two years but not more than five years	51,972		38,163
In more than five years	79,825		80,421
Total	**213,182**		**176,361**

NOTE 34 LOSSES AND SPECIAL PAYMENTS					
	2017/18			**2016/17**	
	Total number of cases	**Total value of cases**		**Total number of cases**	**Total value of cases**
	Number	**£000**		**Number**	**£000**
Losses					
Cash losses	-	-		-	-
Fruitless payments	-	-		-	-
Bad debts and claims abandoned	-	-		12	16
Stores losses and damage to property	2	73		1	54
Total losses	**2**	**73**		**13**	**70**
Special payments					
Compensation under court order or legally binding arbitration award	24	72		25	92
Extra-contractual payments	-	-		-	-
Ex-gratia payments	13	6		24	10
Special severence payments	-	-		-	-
Extra-statutory and extra-regulatory payments	-	-		-	-
Total special payments	**37**	**78**		**49**	**102**
Total losses and special payments	**39**	**151**		**62**	**172**
Compensation payments received		-			-

NOTE 35 RELATED PARTIES

The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24.

The Department of Health and Social Care is the parent department and 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	**2017/18**	**2016/17**
	£000	**£000**
Income - NHS Calderdale CCG	139,399	143,239
Income - NHS Greater Huddersfield CCG	124,146	126,580
Income - NHS North Kirklees CCG	7,368	6,775
Income - NHS Bradford Districts CCG	7,109	7,185
Income - NHS Wakefield CCG	3,673	3,140
Income - Leeds Teaching Hospitals NHS Trust	1,300	1,266
Income - South West Yorkshire Partnership NHS Foundation Trust	3,977	3,760
Income - Health Education England	9,331	8,943
Income- Yorkshire and the Humber Commissioning Hub	23,146	23,294
Income- Yorkshire and the Humber Local Office	5,314	7,364
Income - Other WGA	20,512	34,048
Total Income - Total with WGA organisations	**345,275**	**365,594**
Charitable Funds	311	399
Income - Total	**345,586**	**365,993**
Expenditure - Bradford Teaching Hospitals NHS Foundation Trust	911	1,081
Expenditure - Leeds Teaching Hospitals NHS Trust	2,433	2,139
Expenditure - NHS Pension Scheme	22,893	22,342
Expenditure - NHS Resolution	17,266	15,758
Expenditure - HMRC	18,430	16,594
Expenditure - Other WGA	9,063	7,056
Expenditure - Total with WGA organisations	**70,996**	**64,970**
Joint Ventures	1,403	927
Expenditure - Total	**72,399**	**65,897**
Related party balances - WGA organisations	**2017/18**	**2016/17**
	£000	£000
Receivables - NHS Calderdale CCG	2,095	2,392
Receivables - NHS Greater Huddersfield CCG	1,552	1,173
Receivables - NHS England	3,417	5,198
Receivables - HM Revenue & Customs - VAT	1,331	966
Receivables - Other WGA	4,348	4,406
Charitable Funds	133	72
Receivables - Total with WGA organisations	**12,876**	**14,207**
Payables - NHS Pension Scheme	3,117	3,148
Payables - HMRC	7,853	4,442
Payables - Other WGA	1,681	1,724
Payables - Total with WGA organisations	**12,651**	**9,314**

During the year, the following Board Members or members of the key management staff have declared the following interest or parties related to them.

A Haigh ~ Chair - is a Non Executive Director of Furness Building Society.

D Anderson ~ Non Executive Director - Is Director of Synergy P, Prime Health Huddersfield Ltd and Grange Group Practice.

J Wilson ~ Non Executive Director - Associate Hospital Manager SWYPFT, lay representative Y&H Education England

L Patterson ~ Non Executive Director - is a Director and sole owner of Dr Linda Patterson Ltd, is a Trustee of Health Quality Improvement Partnership.

P Oldfield ~ Non Executive Director - Director and Owner of Tanzuk Consulting holds a position of authority with Sue Ryder Livability and at home in the community, Director for Young Epilepsy.

Prof P Roberts ~ Non Executive Director - is Chair of First Ark group, Vice Chair of Northern Ireland Housing Executive, Ty Hen Holidays LLP Partner.

G Boothby ~ Director of Finance - Is a Director of Pennine Property Partnership LLP

L Hill ~ Director of Planning, Estates and Facilities- is a Director of Pennine Property Partnership LLP.

D Birkenhead ~ Medical Director - is a Trustee of Children's Forget Me Not Trust. Wife- GP Partner at Colne Valley Group Practice. Advice given to BMI Hospital

O Williams ~ Chief Executive - is a Trustee of the NHS Confederation, Director of York Health Economics Consortium.

H Barker~ Chief Operating Officer - Company Secretary and Shareholder of Expert Lighting Direct Ltd which makes sales to NHS.

R Hopkin ~ Non Executive Director - Directorship of Capri Finance Ltd- own consultancy company. Capri Energy Limited - Non Exec Director, Derwent Housing Association Ltd - Non Exec Director. Age UK Calderdale & Kirklees - Finance Consultant, Community Foundation for Calderdale HonTreasurer.
K Heaton ~ Non Executive Director - Independent Board Director of One Manchester Ltd.

A Nelson ~ Director of Alphagrange Consulting Ltd. Non Exec Director with Disclosure and Barring Service and the Law Society.

A Graham ~ Director of Golden Lane Housing, a not for profit company.

In 17/18 there were transactions between Calderdale & Huddersfield NHS Foundation Trust and related parties, additional to those declared under the scope of Whole of Government accounts.
The Foundation Trust had expenditure with Pennine Property Partnership LLP in 17/18 of £1,403,661 (16/17 £927,753)

The expenditure between the Trust and NHS Confederation in 17/18 was £7073 (16/17 £0).
The Foundation Trust had expenditure with Forget Me Not Trust in of 17/18 £0(16/17 £250).
The Foundation Trust had expenditure with Grange Group Practice Fartown in 17/18 of £20,150 (16/17 £21,060).

If you need this annual report in other formats please call 01484 347342

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