Calderdale and Huddersfield NHS
NHS Foundation Trust

(PUBLICATION VERSION)

SUMMARY ANNUAL PLAN 2009/10

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

MAY 2009

Sukhdev Sharma
Chairman

Diane Whittingham
Chief Executive

GLOSSARY

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GLOSSARY

For the reader's ease of reference, the following is a list of terms and acronyms used within this document:

BPPC	-	Better Payment Practice Code
CHFT	-	Calderdale and Huddersfield NHS Foundation Trust
CNST	-	Clinical Negligence Scheme for Trusts
CRES	-	Cash Releasing Efficiency Savings
CRH	-	Calderdale Royal Hospital
EBITDA	-	Earnings Before Interest, Taxes, Depreciation and Amortisation
EWTD	-	European Working Time Directive
FT	-	Foundation Trust
GP	-	General Practitioner
HCAIs	-	Health Care Associated Infections
HCC	-	Healthcare Commission
HRI	-	Huddersfield Royal Infirmary
ICRS	-	Injury Costs Recovery Scheme
IT	-	Information Technology
ISTC	-	Independent Sector Treatment Centre
LDP	-	Local Delivery Plan
Monitor	-	Monitor – Independent Regulator of NHS Foundation Trusts
NEDs	-	Non Executive Directors
NICE	-	National Institute for Clinical Excellence
PbR	-	Payment by Results
PCT	-	Primary Care Trust
RPST	-	Risk Pool Scheme for Trusts
R&D	-	Research and Development
SDS	-	Service Development Strategy
SHA	-	Strategic Health Authority
SIC	-	Statement of Internal Control
SWYMHT	-	South West Yorkshire Mental Health Trust
The Trust	-	Calderdale and Huddersfield NHS Foundation Trust

1. PAST YEAR PERFORMANCE

1.1 Chief Executive's Summary of the Year

Each year presents the NHS with a different set of challenges and 2008/9 was no exception. There were extremely tough national targets to meet, including reducing healthcare acquired infections such as MRSA bacteraemias (bloodstream infections) and meeting the new 18-week referral to treatment target. Both were successfully achieved.

Our staff have cared for record numbers of patients whilst working within the tight financial constraints of the NHS. They have done all this against a background of significant change to our services all of which is designed to ensure our patients continue to receive the highest standards of clinical care we can offer.

It has been an exceptional year. We are constantly asking more of our doctors, nurses, healthcare assistants, cleaners, porters – of everyone here – and they constantly step up to the mark.

In 2008/09 their efforts have brought about real benefits for local people:

- A drop of more than 50 per cent in the number of MRSA bacteraemias and a fall in Clostridium difficile cases
- The shortest waiting times since NHS records began
- Services brought back to Halifax and Huddersfield from centres at Leeds and Bradford
- More hospital services provided in the community and closer to people's homes
- Changes in the way our Children's and Women's Services are delivered

The year also saw more than £1.5 million invested in frontline nursing staff. Our capital programme supported major improvements to more of our hospital wards and £1.1 m in state-of-the-art X-ray equipment. More than £2 million is being spent on updating public lifts throughout Huddersfield Royal Infirmary and more improvements to visitor and patient toilet areas are taking place. We are also taking steps to improve car-parking facilities for patients and visitors.

Much of this work is taking place as a result of careful financial management, which has allowed us to reinvest surpluses for the benefit of our patients.

There is no doubt that the coming years will be difficult for the public sector as well as the private sector. Continued careful management of our resources will be essential in the current economic climate as will our role as a local employer and buyer of local goods and services. We will play a strong role in the local community contributing to the economic stability of both Huddersfield and Calderdale.

In conclusion, I would like to thank our staff, our partners, our volunteers, our members and our patients for all of their help and support.

Diane Whittingham

1.2 Summary of Financial Performance 2008/09

Income and Expenditure 2008/09

The table below summarises the position of the Foundation Trust for the year ending 31 March 2009.

£m	2008/09 Plan	2008/09 Actual*	Variance
NHS clinical income	244.45	248.62	4.17
Non-NHS clinical income	3.75	4.71	0.96
Other income	33.23	37.59	4.36
Total income	**281.43**	**290.91**	**9.48**
Pay costs	(175.03)	(184.94)	(9.91)
Non-pay costs	(89.70)	(88.04)	1.67
Total expenditure	**(264.73)**	**(272.97)**	**(8.24)**
EBITDA	**16.70**	**17.94**	**1.24**
Exceptional items	(3.00)	(3.13)	(0.13)
PDC dividend	(5.77)	(5.77)	0.00
Depreciation	(7.31)	(7.13)	0.18
Other non-operating items	0.92	0.55	0.37
Net surplus/(deficit)	**1.55**	**2.46**	**0.91**

* Unaudited results for the year ended 31 March 2009

In our third year as a Foundation Trust we are pleased to be able to again report a strong financial performance. The plan for the year was to generate a financial surplus of £1.55m. The actual surplus for the year was £2.46m. The increased surplus position was primarily due to the receipt of income above plan for the treatment of patients over contracted levels, offset by increased costs above plan to deliver this additional clinical activity.

The surplus generated will be reinvested in improved facilities and equipment in future years to benefit patient care.

It has been a challenging year in terms of the Cash Releasing Efficiency Savings (CRES) targets that all our divisions were required to deliver, in line with the 3% reduction in the Payment by Results tariff uplift. The CRES target set for all clinical and non-clinical divisions was £7.12m and this was fully achieved.

The planned level of total income for the year was £281.43m, and the actual income of £290.91m represents an over-recovery of £9.48m. Of this additional income over plan, £4.17m relates to additional income generated by clinical activity above levels commissioned by the PCTs. The remaining £5.32m is either from non-NHS sources or

relates to income derived from activities other than the direct provision of healthcare to patients.

To deliver the additional levels of income, additional costs above plan were incurred and our operating costs exceeded plan by £8.24m in 2008/09.

During the year, some exceptional costs were planned for and were incurred. These relate to impairment charges on fixed assets (land and buildings). This was as a result of the general reduction in property prices during 2008/09, a change in the valuation methodology used by our professional team to value our land and buildings (as required by HM Treasury), and the impact of taking some accommodation blocks at St.Luke's Hospital site in Huddersfield out of operational use. These impairment costs did not impact on the cash position of the Trust. These items are considered 'exceptional' in accordance with accounting standards under UK Generally Accepted Accounting Practice (UK GAAP), specifically Financial Reporting Standard 3: Reporting Financial Performance.

Cash Position 2008/09

£m	**2008/09 Plan**	**2008/09 Actual**	**Variance**
EBITDA	16.70	17.94	1.24
Non-cash operational items	0.53	(0.91)	(1.44)
Working capital movements	3.41	3.45	(0.16)
Capital expenditure	(17.83)	(11.79)	6.03
Financing	(0.39)	(0.47)	(0.08)
Net cash inflow/(outflow)	**2.42**	**8.02**	**5.60**
Opening cash balance	**11.05**	**11.05**	
Closing cash balance	**13.47**	**19.07**	**5.60**

The cash balance at the end of March 2009 was £19.07m; the original planned cash position was £13.47m. During the year we had been forecasting an improved year-end cash position. The main reason for the additional cash balance is that capital expenditure for 2008/09 of £11.49m was lower than the £18.99m planned level of expenditure.

Major schemes successfully completed in 2008/09 included:

- Re-roofing Ward Block 2, Huddersfield Royal Infirmary £0.3m
- Neonatal Unit at Calderdale Royal Hospital £0.6m
- Major refurbishment of Ward 17 at Huddersfield Royal Infirmary £1.9m
- Other ward refurbishments at Huddersfield Royal Infirmary £0.3m
- Calderdale Birth Centre £0.5m
- Operational and infrastructure schemes £3.4m

There were a number of specific schemes where actual expenditure on capital schemes was less than planned. Notably, the replacement of the boiler house at HRI was behind plan due to the need to revisit the options available as a result of the change in energy prices. In addition, the replacement of the endoscopy unit at the Calderdale Royal Hospital has not progressed in line with original plans in order to ensure the design solution met all relevant quality standards. The surplus against planned expenditure will be carried forward into next year's capital programme.

Financial Risk Ratings 2008/09

In the Annual Risk Assessment for 2008/09, we assessed our planned financial risk rating to be 4 (from a range of 1 to 5 - high risk to low risk) for each quarter. For each quarter during 2008/09 and for the entire year our actual risk rating has remained at 4.

2. FUTURE BUSINESS PLANS

2.1 Overall Vision

CHFT remains a dynamic and evolving organisation, and continues to grasp the opportunities afforded to it from being a foundation trust. Our business strategy reflects our ambitious intentions to grow real turnover through a combination of increased patient numbers through existing services, development of new services, and acquisitions and partnerships with other NHS and private sector organisations.
We have adopted a new vision, mission, values and goals for our organisation. This encompasses our drive and ambition to become one of the leading foundation trusts in the country.

Our Vision

- Patients- high quality, sustainable patient care
- People- the importance of staff
- Partnerships- the value of our external relationships
- Pride- our standards, achievements and aspirations

Our Mission

- Patients- we will continuously transform care and improve the patient experience
- People- we will attract, retain and develop the best staff
- Partnerships- we will create a sustainable future and develop effective external relationships
- Pride- we will be recognised for our achievements and aspirations as a highly successful organisation

Our Values- based on our pride in the organisation

- Patient Centred
- Respectful
- Innovative
- Developmental
- Engaging

Goals

- To transform care
- Improve the patient experience
- Deliver the regulations
- Develop the organisation for the future
- Enable staff
- Develop talent
- Develop a business approach
- Work with our communities

2.2 Strategic Overview

CHFT is part way through the implementation of its business strategy and we have already seen improvement and growth. There have been significant changes in our environment and economy both nationally and locally which will affect the future direction of this strategy. Such changes will have an impact on how we deliver services to our local communities in both the short and long term. This has made us more determined to continue with plans for growing demand for services, looking at vertical integration of services, particularly of PCT provider services as they are re-organised, and moving to a "hospital group".

We are working with the active support of our local community and partners in delivering our ambitious strategic goals and continue to work hard to ensure ongoing support from PCTs, local GP practices, the patients and public, our members, the local authorities, and our private sector partners.

New Contract

At the end of 07/08 we were given notice by our local PCTs on our existing contract to end March 2009. The new Standard NHS Contract has been negotiated and agreed for the period 2009-2012 and NHS Kirklees has been identified as the lead commissioner. Associates included in the contract are:

- NHS Calderdale
- NHS Bradford and Airedale
- NHS Wakefield
- NHS Heywood, Middleton and Rochdale
- NHS Leeds
- The Yorkshire and Humber Specialist Commissioning Group

A local Contracting Committee has been established which will report to the Contract Management Board. NHS Kirklees will work with the Associate Commissioners in accordance with the Standard Consortium Agreement. We are confident that we will deliver all contract requirements.

2.2.1 National and Local Challenges

There are a number of financial challenges which the Trust faces over the next three years.

In line with the NHS Operating Framework for 2009/10, the contract that has been agreed with the PCTs for 2009/10 is based on the implementation of the new structure for tariffs, Healthcare Resource Group Version 4. Whilst this tariff structure has been subject to some testing across the NHS, its introduction brings an element of uncertainty in terms of being able to robustly predict income levels across the new tariffs.

The inflationary uplift within the 2009/10 tariff includes a national cash-releasing efficiency savings (CRES) target of 3%. Given the pressure on public finances across the foreseeable future, the national savings requirement over the next three to five years is expected to increase further. It is not unrealistic to assume that this figure will reach 5% p.a. at some point across this period. The ability to deliver this level of savings will require a clear strategic direction, strong action planning and performance management. This comes at a time when we need to ensure that continued improvement of the quality of our patient care and outcomes is the driving force for change. The Trust is well placed to deliver on this agenda - the culture of the organisation and the way it is managed promotes clinician involvement and leadership and patient focus at all levels.

CHFT works closely with its two main commissioners, NHS Kirklees and NHS Calderdale. There are regular clinical and commercial meetings including the development of integrated pathways, new service developments and service improvement and transformation, as well as routine contracting boards and committees. CHFT has a developmental and constructive working relationship with its commissioners. All parties understand the importance of delivering improved health to the local population and high quality health services, and we work together to achieve these aims.

CHFT aims to play a role in commissioning development and it recognises the importance of good relationships as well as excellence in clinical services and service delivery. There is an arrangement with the PCTs regarding ‘open’ and ‘closed’ book arrangements for service change. If the PCT plans to take services out to tender, this is made clear and CHFT will withdraw staff from involvement in developing service specifications. This is a ‘closed book’ arrangement. If the PCT plans a service change and has decided this will be done as a service transformation rather than a competitive process CHFT will be involved in the development of the new service specification and the implementation of changes to service to deliver this. This is an ‘open book’ arrangement.

CHFT is happy to support and help commissioners develop their commissioning capabilities and we recognise the importance of maintaining excellent working relationships. Activity planning is a joint process undertaken by the PCTs and CHFT. As this is the case the plans agreed are robust. In the new contract arrangements performance against these plans will be tightly monitored in Contract Management

Boards. Tolerances have been agreed at HRG4 chapter level and statistical process control charts will be used to monitor activity. If activity goes outside the normal range then the mechanisms in the contract will apply and action plans will be agreed. In this way we are confident that we will be paid for all activity.

Demographic changes within the local community will see an increase in the size of the population we serve, and particular growth in over 65s (40%) and 0 to five year olds. These forecasts are used in the annual activity planning process, and the longer term forecasting CHFT is currently completing

The PCTs have been clear that they do not currently have funding available for developments outside of the contract. However, they will fund all activity and CQUIN- the quality investment scheme. The CQUIN scheme has been agreed and the payment structure is the national payment structure.

CHFT has developed data capture mechanisms to ensure delivery of the information required for the scheme, and also put in place specific projects to improve clinical quality for the schemes targeted areas.

CHFT is pleased that it has received unconditional registration from the Care Quality Commission (CQC). This is in recognition for the high quality services and care we provide.

As the third biggest organisation in the area the Trust recognises the considerable contribution it can make to skills, health, employment and reduction of health inequalities by virtue of how it does business. CHFT has an active role in both the Calderdale and Kirklees Local Strategic Partnerships. We are talking to partners about:

- The forecast impact on the local economies of the economic downturn. This is of particular concern in Calderdale as a large proportion of its GDP comes from financial services (Lloyds/HBOS)
- Where CHFT can help deal with some of the consequences of the downturn, especially with local businesses and employment opportunities
- Forecasting the impact on health services, as demand is expected to rise. These forecasts will be used as part of the joint planning processes with PCTs to support the contract and the delivery of national targets. If forecasts are different to what actually happens, this will be reported through to the Executive Board and Board of Directors and joint action plans will be delivered to ensure patients are seen and targets delivered

One of our hospitals, Calderdale Royal; Hospital, is based in Halifax and we provide health services for the population of Calderdale. We are working closely with Calderdale Council to help to resolve some of the issues raised by the difficulties at HBOS, a major employer in the district. The Lloyds/HBOS Board has been clear about the town centre and transport improvements it wants to see in Halifax if it is going to continue to use Halifax as one of its main centres. CHFT needs to look at where services are delivered in Halifax town centre, and is working with Calderdale Council

to see if we can redevelop facilities and help to improve the centre's environment as part of the process.

CHFT has noted the requirements of the principles and rules on cooperation and competition and work within these rules. Local PCTs have clear procurement policies, which we have access to, and we use these to manage commercial arrangements between organisations.

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The tightening of available resources across the public sector will mean that the ability to finance additional capital expenditure over and above those schemes which are primarily about replacement rather than development or enhancement will be limited. The Trust has put in place a capital programme over the next three years that addresses its key priorities. The Trust has the opportunity, through the disposal of St. Luke's Hospital site in Huddersfield to ensure that the remaining assets that we provide services from (including the Acre Mills site in Huddersfield, which is yet to be fully developed) are fit for purpose and support the delivery of excellent patient care.

In addition to the general financial and economic outlook for the Trust, there are some specific challenges which have been factored into the financial planning process. These include:

- The shortfall in funding received via tariff inflation to address the increase in the contributions paid to the NHS Litigation Authority

- The pressures on staffing costs resulting from the implementation of the European Working Time Directive, Staff and Associate Specialists pay reform and incremental movement as a result of Agenda for Change payscales

- The potential for growth opportunities as well as income loss as a result of increased competition for healthcare services

2.2.2 Quality Plan 2009/2010

Quality has always been at the very heart of what we do. The structure of our organisation, and the culture we have strived to develop, is one that promotes and supports high quality care and high quality people.

The benefits of the way we work have been shown nationally through the health service rating system – we have performed strongly for many years and, during the last two years have been awarded the top, "double excellent" rating by the Healthcare Commission.

In 2006, we made a bid to join the Safer Patients Initiative as a pilot site – a further demonstration of our commitment to patient safety and quality. We went through a highly competitive selection process and were one of just ten trusts nationwide to be successful.

During the 18-month project, our staff took on board a new approach to patient safety. What were then new methods of working, are now day-to-day practice.

The benefits of the project have already included:

- A fall in the number of MRSA bacteraemias (bloodstream infections)
- A fall in the number of infections caused as a result of inserting central lines
- Reductions in ventilator acquired pneumonias
- Increased implementation of measures to prevent surgical site infections.

The move to join the Safer Patients Initiative three years ago was a natural next step on our journey to improve the quality of our care - and this is a journey we are continuing. We listen to our patients, our membership, and our other stakeholders and respond where we can – keeping quality at the heart of everything we do.

Overview of leadership of quality

Our involvement in the Safer Patients Initiative (SPI) has given us many practical tools to improve the safety and quality of different elements of patient care. The overarching aim of SPI, is to change the culture of the Foundation Trust to one which has zero tolerance to avoidable death or harm. We have developed a leadership culture at Board level, that promotes quality and patient safety, and provides an environment where staff are empowered to continuously improve their services.

Over the last two years, executive and non-executive directors have carried out over 150 leadership walkrounds. This has enabled them to engage with front line staff, who have been encouraged to identify and find solutions for any safety or quality issues they may have. Where necessary, teams have been supported to find solutions, using the practical SPI tools.

At the beginning of our SPI journey, we carried out a safety climate survey, involving a large cross-section of our clinical staff. This has been repeated during 2008/09, and has shown improvement.

How we have prioritised our quality improvement initiatives

The Foundation Trust is involved in many quality improvement initiatives, for example:

- We are one of four organisations chosen to participate in the Health Foundation's new initiative "Improving the Safety of Maternity Services through Teamwork Solution".
- We are working with the Department of Health's National Orthopaedic Improvement team, to improve the pathway for patients who suffer a fractured neck of femur.
- We are keen to improve the experience and outcomes for patients with learning difficulties. We have appointed a Matron for patients with complex needs, who works closely with this patient group. We have developed VIP (Vulnerable In-

Patient) cards for patients, which provides useful information on their needs and preferences. These are examples of exciting initiatives, but after careful consideration our Medical Director and Director of Nursing have selected the following three priorities:

Priority 1: To further reduce the incidence of MRSA and C-Difficile infections.

Priority 2: For patients who have suffered fractured neck of femur, to improve the timeliness of surgery, and reduce morbidity, mortality and length of stay.

Priority 3: To increase the score relating to the rating of overall quality of care, provided by patients in the National Patient Survey.

We will, of course, also be monitoring our performance against other quality metrics, including those developed by NHS Yorkshire and the Humber. Their Quality Assurance and Improvement Scheme includes indicators linked to the eight priorities in the Healthy Ambitions programme, which aims to save lives and improve care for our population over the next ten years.

Priority 1:
To further reduce our Healthcare Acquired Infection (HCAI) rate in line with our target.

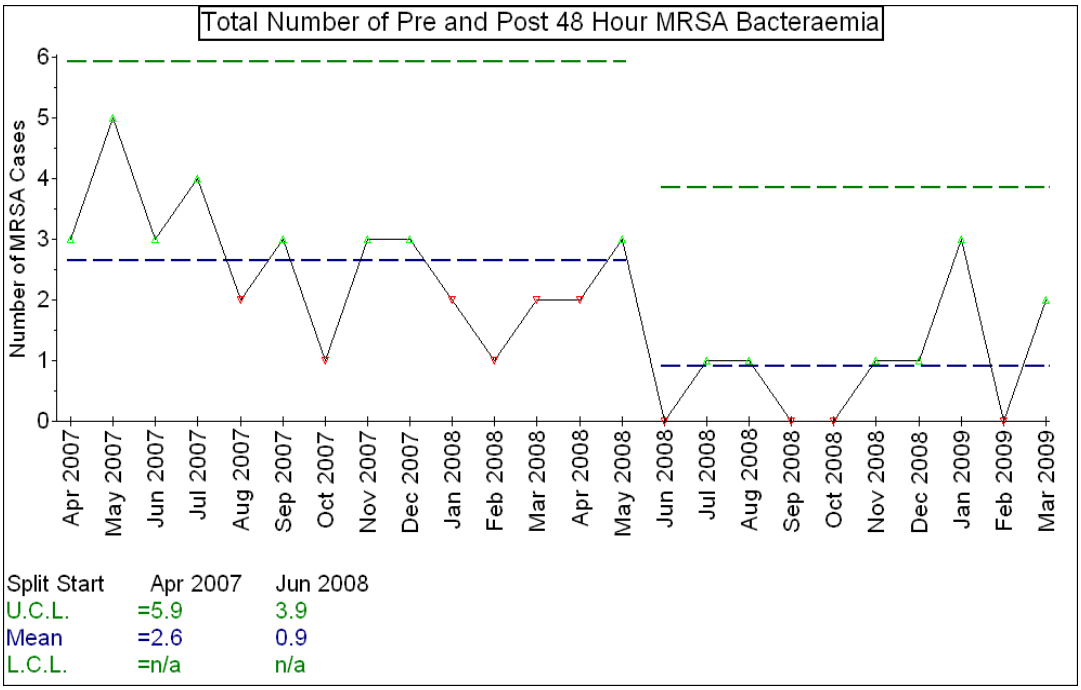
Description of issue and rationale for prioritising

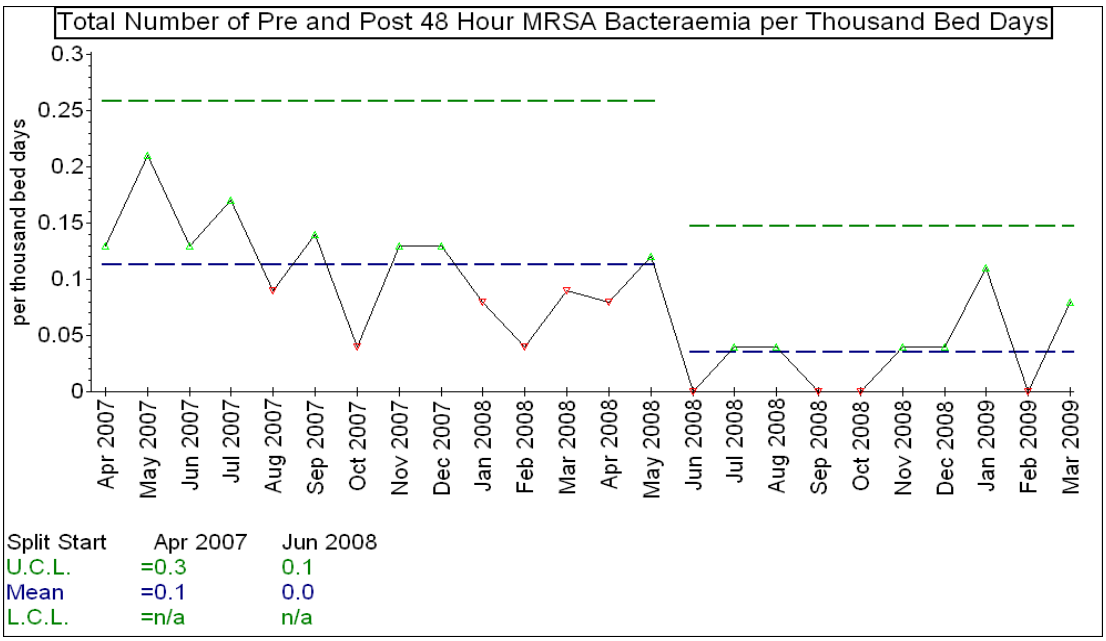
Our current MRSA rate is below the national average, but we believe we can introduce measures to reduce it further, in line with national priorities. The Trust is committed, in particular to change clinical practice to prevent and control healthcare associated infections, including MRSA, as outlined by the DoH in both the 'Winning Ways' action plan document and 'Saving Lives' programme, and the Health Act 2006 : Code of Practice for the Prevention and Control of Healthcare Associated Infections.

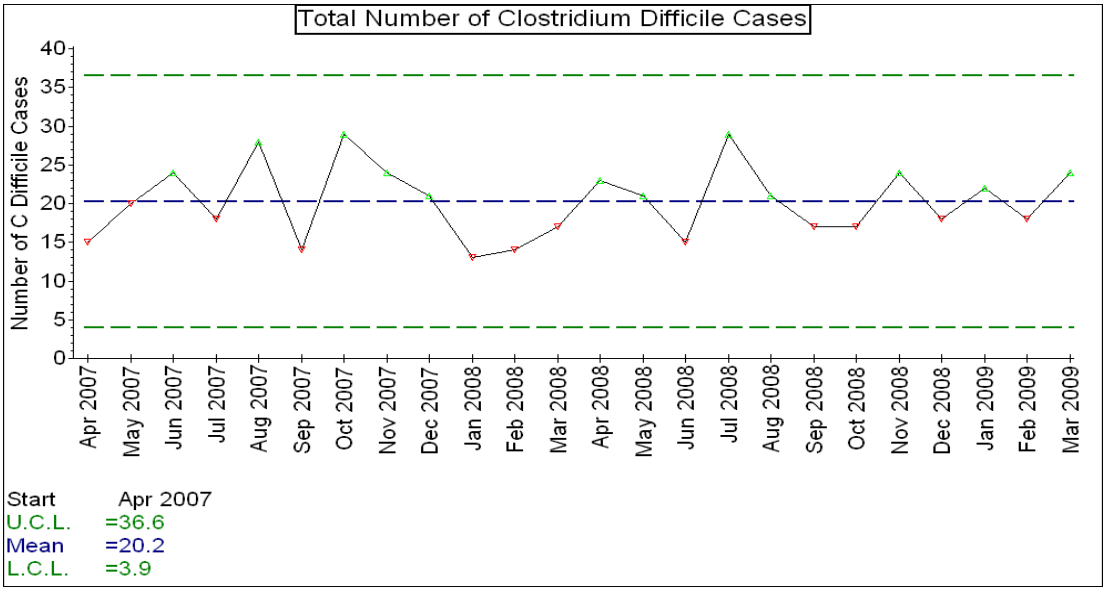
Aim/Goal

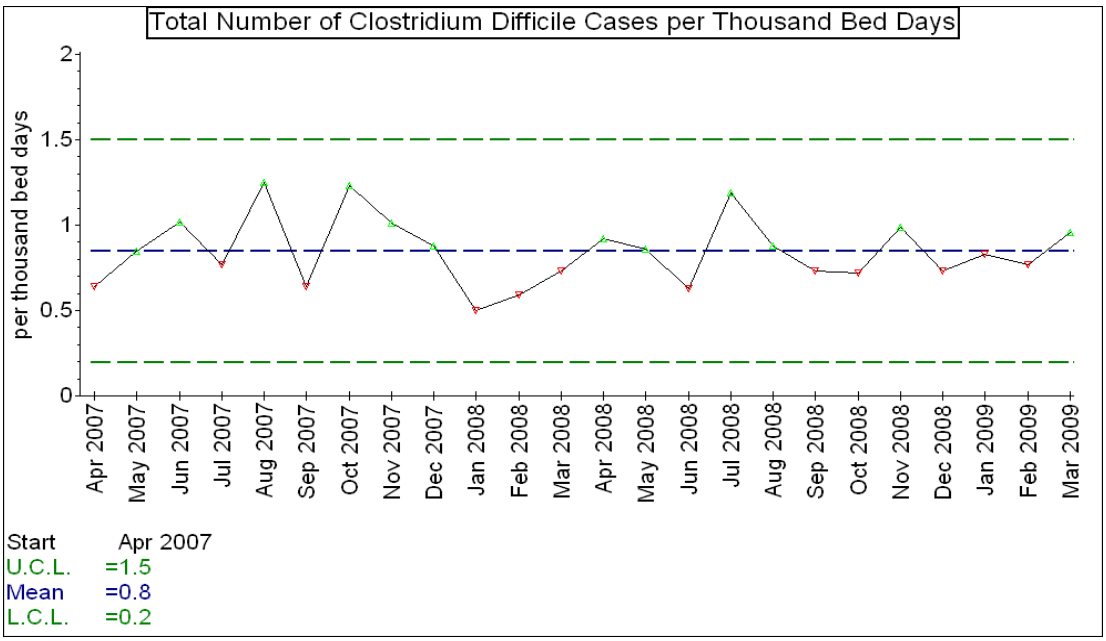
To reduce the incidence of MRSA bacteraemias and C Difficile infections.

Current status




Total Number of Pre and Post 48 Hour MRSA Bacteraemia per Thousand Bed Days
per thousand bed days
0.3
0.25
0.2
0.15
0.1
0.05
0
Apr 2007
May 2007
Jun 2007
Jul 2007
Aug 2007
Sep 2007
Oct 2007
Nov 2007
Dec 2007
Jan 2008
Feb 2008
Mar 2008
Apr 2008
May 2008
Jun 2008
Jul 2008
Aug 2008
Sep 2008
Oct 2008
Nov 2008
Dec 2008
Jan 2009
Feb 2009
Mar 2009
Split Start Apr 2007 Jun 2008
U.C.L. =0.3 0.1
Mean =0.1 0.0
L.C.L. =n/a n/a


Total Number of Clostridium Difficile Cases
Number of C Difficile Cases
40
35
30
25
20
15
10
5
0
Apr 2007
May 2007
Jun 2007
Jul 2007
Aug 2007
Sep 2007
Oct 2007
Nov 2007
Dec 2007
Jan 2008
Feb 2008
Mar 2008
Apr 2008
May 2008
Jun 2008
Jul 2008
Aug 2008
Sep 2008
Oct 2008
Nov 2008
Dec 2008
Jan 2009
Feb 2009
Mar 2009
Start Apr 2007
U.C.L. =36.6
Mean =20.2
L.C.L. =3.9



Identified areas for improvement

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

Current initiatives in 2008/09:

- Establishment of Link Infection Prevention and Control Practitioners
- Showcase hospital project – trialling and evaluating new innovations and technologies to help reduce HCAI's
- Development of antibiotic guidelines
- Establishment of hand wash champions
- Intensive environment/infection control audits
- Introduction of Invasive Devices Clinical Nurse Specialist Team

New initiatives to be implemented in 2009/10:

- Bio-Medical Scientist Infection Control Advanced Practitioner – to look at new methods of testing
- Review of antibiotic guidelines
- Antibiotic ward rounds
- Screening of all patients for MRSA, both on admission and prior to surgery
- Ongoing monitoring of process and outcome measures

Priority 2 :

For patients who have suffered fractured neck of femur, to improve the timeliness of surgery, and reduce morbidity, mortality and length of stay.

Description of issue and rationale for prioritising

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

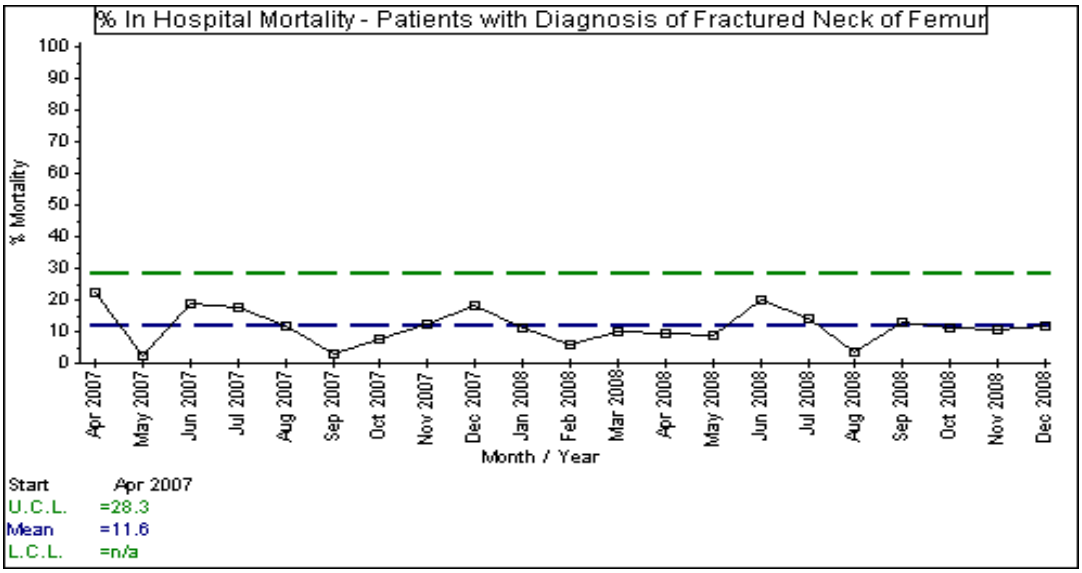
Aim/Goal

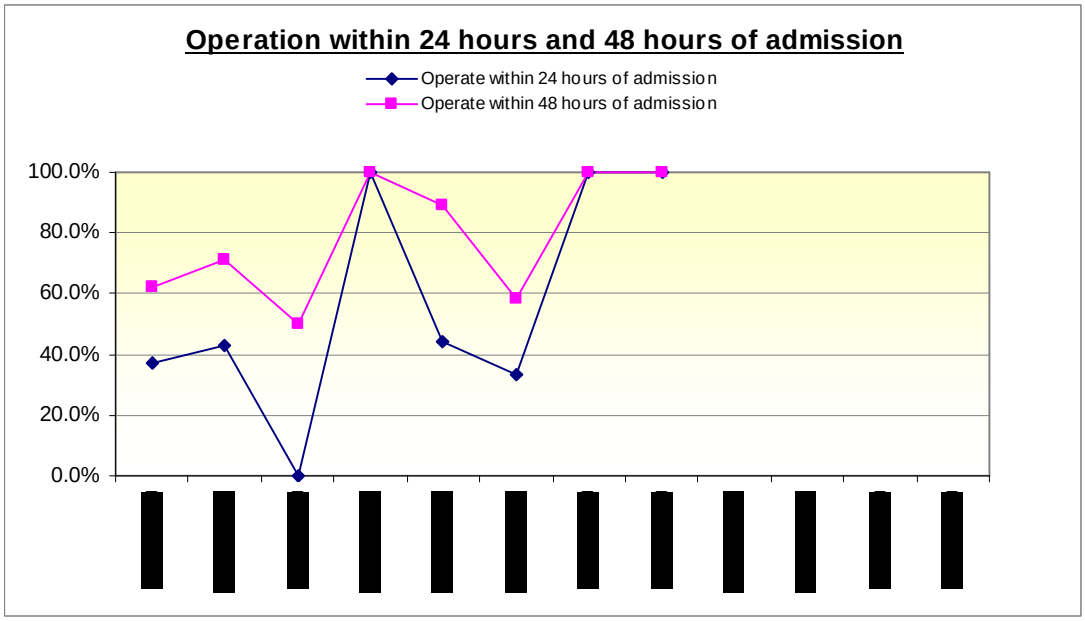
To improve the pathway of patients with fractured neck of femur by ensuring that all medically fit patients have surgery within 48 hours of admission to hospital.

Identified areas of improvement

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

Current Status





Current Initiatives in 2008/09

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

New initiatives to be implemented in 2009/10

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

Priority 3 :

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

Description of issue and rationale for prioritising

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

Aim/Goal

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

Current status

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

Identified areas of improvement

- Insufficient patient feedback throughout the care pathway
- Nurses need more time to provide direct patient care
- We still have some "mixed sex" accommodation on the assessment wards

Identified areas for improvement as a result of our Patient Survey

- An open space event will be hosted by the Chief Executive to engage staff and members with a passion for championing and role modelling behaviour.

- There will be a sustained campaign following a launch process to ensure the patient experience and in particular interactions with patients and their relatives is at the forefront of thinking and actions.

- The inpatient survey will be repeated again to follow up the last action plan and will then be repeated quarterly.

- Localised inpatient surveys, currently being trialled will be conducted weekly across wards and departments supported by Matrons.

- Every ward and department will have an individual action plan for this survey.

- Every member of staff will participate in the Delivering Excellent Service programme.

- Unannounced visits to wards and departments will be made by the Director team to spot check patient experience.

- The Exemplar Ward Development programme (about to be launched) will be a key platform for bringing together safety, effectiveness and patient experience at ward level.

Current initiatives in 2008/09

- All ward areas have completed the NHS Institute for Innovation and Improvement's Good Practice Guidance and Self Assessment Audit around Promoting Privacy and Dignity – The Elimination of Mixed Sex Accommodation.

- Mandatory training in either "Delivering Excellent Service" or "Managing the Delivery of Excellent Service".

New Initiatives to be introduced in 2009/10

- Action plan to eliminate mixed sex accommodation to be delivered.

- "Productive Ward" initiative to be rolled out to wards, with the objective of releasing nurses to give more time to providing direct patient care.

- Introduction of Patient Reported Outcome Measures (PROMS).

- Introduction of mechanisms for "real time" patient feedback.

Response to Regulators

- Calderdale and Huddersfield Foundation Trust's declaration to the Care Quality Commission indicated our compliance with all of the core standards.

- In response to concerns from Monitor, we have reduced the incidence of MRSA bacteraemia and achieved our annual target in 2008/09.

- The Healthcare Commission carried out a follow up review of children's hospital services. The review focused on the training and skills required to meet the needs of children in hospital, with particular emphasis on care settings such as emergency care, day case care, surgery and out- patients. Results showed slight improvement against the original review. Whilst the follow up review was published in March 2009, it related to data for the period Oct 2006 – Sept 2007. Data collected for the current year has shown much greater improvement, and an action plan has been developed to further align our service to the required standards.

- Following the Healthcare Commission's inspection of our compliance with elements of the Hygiene Code, the Trust has made improvements in a number of focussed areas, alongside existing infection prevention and control priorities during 2008/09. The sustained commitment to these areas of work has culminated in a significant reduction in our MRSA and Clostridium Difficile rates.

Response to Local Involvement Networks (LINks) and to feedback from Foundation Trust (FT) Members and the Membership Council

The Trust has forged working relationships with LINks in both the Calderdale and Kirklees areas. This has resulted in a number of opportunities for the LINks members to express views about services provided by the Trust. Examples of these include:

- The Membership Council has held two workshops with LINks to explore how to best work together effectively

- LINks met with the Head of Patient and Public Involvement and representatives from the Obstetric team to discuss breastfeeding rates, this provided an opportunity to talk about the initiatives in place to promote breastfeeding.

Each Division holds two focus groups a year, attended by FT members. The first provides an opportunity to shape divisional business plans, and the second allows for ongoing debate on progress.

Divisional reference groups are also held with representatives from the Membership Council, who give feedback on areas of work they have been involved in, such as PEAT visits and 'mystery shopper'. These have been successful in offering a patient and public perspective to divisional business.

Examples of issues raised and being worked on jointly with LINks/FT members/Council Members:

- Concerns over the Pharmacy waiting area at Huddersfield Royal Infirmary
- Audiology pathway/waiting times
- Assessment and management of pressure sores

Quality Overview

Performance of the Trust against self selected metrics

We have chosen to measure our performance against the following metrics:

Safety Indictors	**Source of Indicator**	**2007-2008**	**2008-2009**
1. Adherence to antibiotic prescribing policy	SPI	Not collected	91.8%
2. Hand hygiene compliance	NPSA	73.9% (Nov to March)	99.4%
3. Medicines reconciliation	SPI	66.52%	79.86%
4. Incidence of Venous thrombo-embolism	Internal	Not collected	289 (Aug to Feb)
5. VTE prophylaxis given as prescribed, prior to surgery	SPI	93.07% (May to March)	96.10%

Clinical Effectiveness Indicators:	Source of Indicator	2007-2008	2008-2009
1. In-patient mortality rate for patients with fractured neck of femur	Internal	11.89%	11.16%
2. Surgery for fractured neck of femur within 24 hours	DoH	Not collected	Not collected for full year
3. Surgery for fractured neck of femur within 48 hours	DoH	Not collected	Not collected for full year
4. Emergency readmission following discharge after surgery for fractured neck of femur	Internal	12%	4.6%
5. Emergency readmission following discharge (adults)	Internal	10.3%	10.5%

Patient Experience Indicators:	Source of Indicator	2007-2008	2008-2009
1. Compliance with DoH guidance on Mixed Sex Accommodation	DoH	Compliant	Compliant
2. Overall, how do patients rate the care they received (maximum score 100)	National In-Patient Survey	78	76
3. Did patients feel they were treated with dignity and respect whilst in hospital (maximum score 100)	National In-Patient Survey	87	86
4. In patients' opinions, were there enough nurses on duty to care for them (maximum score 100)	National In-Patient Survey	69	71
5. Do patients feel that we have communicated with them well. (Questions 3,29,33,38,40,49,50,62,63,64 in the 2008 survey). (maximum score 100)	National In-Patient Survey	77	75

Note on indicator 5: an average score has been calculated, for 10 questions in the patient survey which relate to communication.

2.2.3 Key Actions

- **Contracts**

We have just agreed the new three-year contract with our PCT commissioners. Our lead commissioner is Kirklees PCT and they led the PCT contracting process on behalf of the other local PCTs. There are strong and established contract

management arrangements in place, including a Contract Management Board, a Contracting Committee and a Clinical Quality Review meeting.

- **Local Implementation of Health Policies**

All of our local PCTs have frameworks in place to role out the implementation of health policy. In Kirklees PCT these are through Health Improvement Teams (HITs) and in Calderdale PCT these are through different programme areas. We are involved in this work and helping to make change happen.

Locally we have teams within the Trust delivering changes to services, and the provision of services to deliver new policies.

- **Patient Safety and Service Delivery**

CHFT has been part of the Safer Patients Initiative led by IHI. Whilst this initiative has now finished, the improvements are still continuing and these are still being supported by the local Safer Patients team. The Trust is also rolling out the Productive Ward improvement methodology, which has been supported by our local PCTs.

CHFT has been rolling out service improvements using “lean” methodology. A number of areas have been “leaned” including histopathology, HR, and the Pharmacy Manufacturing Unit. We have 10 staff that are qualified to NVQ level 2 in Lean, and further training is taking place to develop NVQ level 3 staff in Lean, and a further cohort of NVQ level 2 staff in Lean. The Service Improvement Team helps and supports service improvements across the Trust, and helps to develop local skills for improvement work. During 2009/10 some “value stream” work will be completed across the whole of the acute pathway. This work should improve the patient experience, improve patient safety, and also reduce lengths of stay.

- **Commissioning Intentions**

Both local PCTs have issued their operating plans for 2009/10, their Commissioning Strategies, and their medium term financial plans. CHFT is working with the PCTs to understand how this will affect their future commissioning intentions. The PCTs have wide-ranging plans for the future, which include work in ophthalmology to reduce inappropriate referrals, community services to reduce acute admissions, and GP enhanced services to deliver more from primary care. However, these need to be put against future population demographics which will see a rise in both the size of the local population, and changes to the age profile. There will be 40% more over 65s by 2018, and a rise in 0 to fives. Further in-depth work will be carried out during the course of 2009/10 to look at future demand for secondary care services to ensure that specialties are able to deal with the volume of demand in the future, which in specific specialties - ophthalmology, orthopaedics and care of the elderly - is expected to dramatically increase.

- **Competition within the Local Health Environment**

Presently there are two private hospitals within the Calderdale and Kirklees area. They are both on Choose and Book and are receiving small numbers of referrals (about 100 a month). CHFT has good links with both providers and has regular meetings. The number and type of referrals is being monitored to determine any future impact.

Both local PCTs are also starting to bring in new providers for some primary care services including GP out-of-hours services and extended primary care. Care UK now runs the GP out-of-hours service in Calderdale as well as several GP practices. CHFT has developed a good working relationship with Care UK, and is looking at how this can be used to develop services in the future.

GP practices in local PCTs are being encouraged to extend the range of services provided in line with national policy. Practices are supported to develop business cases to introduce new services at practice level, some of which should reduce referrals into secondary care. CHFT is developing outreach services, and will put services into GP practices if time and space allow. In this way we aim to help skill up GPs and other practice staff to improve referrals, provide local services to patients, and ensure no significant reduction in referrals.

- **Marketing Proposals**

CHFT has a marketing strategy and marketing action plans for each division. Regular information is produced looking at referrals by GP practice as well as where referrals are sent. We are continuing to look at communication and reputation management, with a particular focus on customer care and relationships at a clinical level. Our Delivering Excellent Service programme is still being rolled out across the organisation plus the joint training initiatives we have in place with GPs and consultants.

We are working with other local trusts to ensure we have good quality, strong services in place for those specialties who need a wider population base to be sustainable into the future. We are also looking at services that could be delivered locally instead of patients travelling to a tertiary centre to receive care.

- **Relationships with Healthcare Stakeholders and Local Authorities**

CHFT has good working relationships with all the local PCTs, at both a managerial and clinical level. Clinicians, in particular consultants, are actively encouraged to improve communication with primary care, especially GPs, as this is seen as vital for patient care and safety.

CHFT also works hard to maintain a good relationship with the SHA, and both local authorities. We have had Director Team to Team meetings with Calderdale Council, and have identified some specific areas to work on. We also have regular meetings with Directors of Adult Care in both Calderdale and Kirklees Councils, along with PCT provider services to ensure there are no issues with patient flow across organisations. We are involved in both LSPs, and their sub-groups, and take an active role in

implementation of the Local Area Agreements, and Kirklees Comprehensive Area Assessment, as they are one of the pilot areas.

2.2.4 Service Development plans

The Trust has identified the following priority service developments for progression in 2009/10.

- **Bowel Screening**

Following April's live opening of the Calderdale, Huddersfield and Wakefield Bowel Screening Centre for the populations of Calderdale and Huddersfield, the centre will now focus on the 2nd phase implementation at the Pinderfields site for the residents of Wakefield and North Kirklees. With specialist screening interviews being held in community locations, this initiative has truly grasped the ethos of care closer to home and partnership working to a wider health community. Phase 2 will be completed in July 2009. The initiative will generate £1 million of income plus additional funding for self referrals over the age of 70 years.

- **Cardiology**

2009 will see the implementation of the Trust Cardiology Strategy with a revised approach which will see the local repatriation of patients undergoing elective angioplasty. This service will provide ease of access for patients who have previously travelled to Leeds and secure additional service capacity.

- **Rheumatology**

The repatriation of some day case and outpatient activity is ongoing for those patients who currently have to travel to Leeds for treatment using biologics infusions and injections, and other rheumatology interventions. The rheumatology service continues to work as part of the Integrated Service Improvement Programme, a DH pilot site for the management of long-term conditions, and as part of the Health Foundations "Co-creating Health" Programme. Expansion of community-based rheumatology services and the pathways for self-care are expected in 2009/10.

- **Long-Term Care – Community Respiratory Services**

The Trust has submitted a tender to host the Kirklees Integrated Community Respiratory Services for Huddersfield patients. The service will focus on community delivered care as part of a structured approach towards implementing pathways for Long Term Conditions. The clinical pathway has been developed in consultation with clinicians from CHFT and Mid Yorkshire Hospitals NHS Trust and has an anticipated income of £1.2 million.

- **Genito-Urinary Medicine**

With the appointment of a new consultant the Trust can build upon the already excellent GUM and HIV services and expand capacity to meet the growing demand in this area.

- **Maxillo Facial Surgery**

Building upon the successes of the day case plastic surgery service, the Trust is now looking to extend this provision to Maxilla Facial day case procedures and is developing a joint consultant post with Bradford to enable this facility locally.

- **Bariatric Surgery**

The Trust's strategic decision to grow this service has been supported by our local commissioners, and by the Specialist Commissioning Group for Yorkshire and Humber, who have approved CHFT as a designated provider for obesity surgery. This is anticipated to add strength for the Trust portfolio and additional capacity has already been commissioned for out of area referrals through the Specialist Commissioning Group. The Appointments Committee is meeting in May to consider the appointment of a third bariatric surgeon.

- **Aneurysm Screening**

The Trust is working in collaboration with the Bradford Teaching Hospitals Foundation Trust, Airedale NHS Trust and the Mid Yorkshire Hospitals to develop an Abdominal Aortic Aneurysm Screening Service in line with the NICE guidance and the service specification requirements of the Specialist Commissioning Group. A business case has been developed and the collaborative has been asked to submit a second wave bid for implementation in early 2010.

- **Ophthalmology**

The demand for this service is growing, and will continue to grow into the future (our over 65 population will increase by 40% by 2020). We already deliver a macular degeneration service for a large population area, and with the changes in the NICE guidance (2008) we have seen a significant increase in this field including out of area referrals. We are already increasing capacity in this service, and work is ongoing to forecast the demand short and long term. This will be reflected in our Ophthalmology Business Strategy to ensure we make the most of the growth in demand for the next five to 10 years.

- **Stroke Services**

This year we will be improving our acute stroke services to provide tertiary level care. This will increase our market potential in this area and repatriate patients who are currently travelling to Leeds for urgent carotid surgery. Our clinicians are working in collaboration with Bradford to ensure best practice is delivered in a consistent manner across the region.

- **Outreach Services**

Building upon the excellent progress made at the Todmorden Health Centre, the Trust will be grasping opportunities to expand outreach services, with particular focus on the proposed third party development in Brighouse and the community hospitals developments at Princess Royal Hospital and the Holme Valley Memorial Hospital in Kirklees. All three areas are in prime locations for releasing sufficient capacity on the main sites and to attract out of area referrals from the Barnsley, Sheffield and Wakefield borders.

- **Maternity Matters**

By the end of 2009 the Trust will be able to demonstrate that we are able to offer a choice to pregnant women of how they access maternity care, the type of antenatal and postnatal care they wish to receive, and a choice of their place of birth. Significant developments are ongoing with the support or our commissioner to meet these requirements and to ensure that we are the provider of choice to an extended community.

- **Productive Ward**

The Productive Ward has been developed by the Institute for Innovation and Improvement and has received Department of Health backing for its widespread introduction and implementation. Much of the methodology and knowledge transfer has come from the motor industry and is based on LEAN principles and has a high evidence base. The Productive Ward consists of 15 specific modules which contribute to the care of patients on wards and capture common themes of productivity. It is clear that there will be significant benefits in terms of quality of care, efficiency and effectiveness, and patient safety. This will have major benefits in releasing time to care at the bedside, valuing and gaining the maximum output from our biggest resource – our staff, enabling nurses in particular to deliver high quality care for our patients whilst gaining personal job satisfaction. The Trust has highlighted this as a priority development over the next three years and has secured funding from the DH and our local commissioners.

- **Improving Discharge Processes**

In 2009/10 the Trust will be focusing service improvement resources towards the improvement of patient discharge processes. A project team will be working to identify efficiency gains through improving the quality and timeliness of administration and communication methods both internally and with our GP's and Local Authorities. This will enhance our bed/theatre utilization and is expected to generate financial resources towards future CRES programmes.

- **Mixed Sex Accommodation**

In response to the new guidance for Mixed Sex Accommodation the Trust has submitted a bid to the SHA to support the capital estate schemes required for

compliance. The key risks have been identified and the board has agreed the preferred options to meet the requirements. A work schedule has been drafted together with an operational policy for Single Sex Accommodation. Engagement with our staff, patients and public will take place throughout the months of May and June (two weekly progress reports have/are submitted to the PCTs and the SHA). The Trust is expecting to be fully compliant in line with the end of June deadline.

- **Interventional Radiology**

There is a growing market for interventional radiology procedures in particular vascular techniques. This innovation will result in fewer post-operative complications, reduced length of stay and better theatre utilisation. The introduction of EVAR (Endovascular Aneurysm Repair) for Abdominal Aortic Aneurism (AAA) repair will support our application for screening status and provide sufficient capacity for out of area referrals. With the introduction of the NICE Guidance for AAA, this has been identified as a rising star in our divisional marketing plans for 2009/10.

- **Paediatric Orthopaedic Day Case Surgery**

From May 2009 we will be offering specialist outpatient appointments and day case treatments for paediatric orthopaedics. Currently patients are travelling to Leeds for consultations and procedures.The service will be delivered by a consultant outreaching from the Leeds Teaching Hospitals and will be offered as a choice to all patients within the region with a focus on repatriating Calderdale and Huddersfield patients locally.

- **Satellite Renal Dialysis**

The Trust is working with The Leeds Teaching Hospitals to develop a capital business case for the delivery of Renal Dialysis on the HRI site. Negotiations are ongoing and this proposal is fully supported by our commissioning PCTs.

- **18 Weeks Referral to Treatment Timescales**

The Trust has made significant progress in this area and achieved a healthy aggregate position at the end of 2008/09. Further work is ongoing to ensure sustainability at speciality level throughout 2009/10 by the implementation of robust whole system pathway reform.

- **IVF**

In 2009/10, the Trust is looking to build upon its excellent reputation in this field and further develop outreach IVF services to North Kirklees and East Lancashire and is exploring the options afforded to us as a Foundation Trust to embrace a future as a ‘stand alone unit’ for IVF.

- **Reconfiguration of Services**

As well as improving patient safety, our reconfiguration of services has enabled us to improve the efficiency and safety of service delivery. We intend to use this capacity to deliver more patient care to a wider population base. We will continue to increase the number of births at Calderdale Royal Hospital from Bradford residents. In addition, we will attract a variety of work from Calderdale and East Lancashire residents who historically have been treated in Lancashire via our new service in Todmorden.

Private patient income

Private patient income in 2008/09 accounted for 0.11% of our total patient related income. This is within the maximum level of 0.4% that we have been set as part of our terms of authorisation as a Foundation Trust. The table below shows that the Trust was compliant for 2008/09 and plans to remain within the limit across the three-year planning period.

	Plan	Actual	Current plan		
£m	**2008/09**	**2008/09**	**2009/10**	**2010/11**	**2011/12**
Private patient income	0.46	0.29	0.53	0.54	0.55
Total income from activities	248.20	253.33	265.80	272.050	274.770
Proportion as a %	0.19%	0.11%	0.20%	0.20%	0.20%

2.3 Summary of Financial Forecasts

2.3.1 How the plan was built

The financial planning process for 2009/10 was undertaken in the context of the previous three-year plan for 2008/09, 2009/10 and 2010/11 submitted to Monitor in May 2008, and the in-year financial performance in 2008/09.

All of the clinical and non-clinical divisions have been fully involved in the process for setting the 2009/10 plan. The key stages for setting the plan have included:

- Assessing the resource implications of changes in activity levels commissioned via the clinical contracts with the PCTs
- Setting the levels of Cash Releasing Efficiency Savings to be delivered by the divisions
- Understanding inflationary cost changes
- Identification and prioritisation of pressures and developments

Within these stages, the approach has been to share Trust-wide planning assumptions as early as possible with each of the divisions, working on resource and activity changes, and ensuring a shared understanding about the relative priorities of developments.

Full discussions around the above have been held via the monthly Divisional Finance and Performance meetings where Divisional Management teams meet with a number of the Executive Directors to discuss and work together on key service and financial issues.

In addition, the strategic context and operational response to the challenges faced by the Trust over the coming years has formed a key part of the discussions held at Board of Directors, Executive Management Board and the Membership Council (Board of Governors).

2.3.2 The impact of International Financial Reporting Standards

The Trust has fully considered the accounting adjustments required to move from UK GAAP (UK Generally Accepted Accounting Practice) to International Financial Reporting Standards (IFRS). The key change is the accounting treatment adopted for the Private Finance Initiative (PFI) contract at Calderdale Royal Hospital. The Trust sought professional advice from an accountancy firm towards the end of 2008 to assist in this change. This work concluded that the PFI asset should be considered as an on-balance sheet asset under IFRS, whereas under UK GAAP the asset had been treated as off-balance sheet.

The Trust submitted a draft restated 1 April 2008 balance sheet under IFRS to Monitor and external audit at the end of December 2008 in line with the Monitor timetable. The Trust then commissioned a review of the arrangements in place to restate these balances from our external auditors, the findings of which were reported to the Audit Committee and Board of Directors. In early April 2009, the Department of Health issued some further guidance on the treatment of PFI schemes under IFRS. Whilst Foundation Trusts are not obliged to follow this guidance, the proposals in this guidance was felt to be more appropriate to the Calderdale Royal Hospital contract and, following a full discussion at the Audit Committee, the ‘audited’ submission on 1 May 2009 was amended accordingly to reflect key elements of this guidance.

The transactions to account for the PFI contract under both UK GAAP and IFRS are relatively complex. The tables below detail the 2008/09 financial position as it would have been reported under IFRS.

£m	2008/09 Actual
Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA): as shown under UK GAAP	**17.94**
Adjustments to move from UK GAAP to IFRS	
- UK GAAP transactions to be taken out	(1.35)
- IFRS: reclassify part of Unitary Payment to finance lease rental	11.28
Earnings Before Interest, Taxation, Depreciation and Amortisation (EBITDA): if prepared under IFRS	**27.87**

The table above shows that EBITDA (which is a measure of operating surplus/deficit) increases under IFRS. This is mainly because the payment to the PFI contractor was previously classed as an operating cost; under IFRS an element of the payment is categorised as a finance lease cost and as such is not accounted for a charge against EBITDA.

£m	2008/09 Actual
Income & Expenditure Surplus: as shown under UK GAAP	**2.46**
Adjustments to move from UK GAAP to IFRS	
- UK GAAP transactions to be taken out	(1.35)
- IFRS: lifecycle costs to capitalise	0.23
- IFRS: repayment of finance lease	1.35
- IFRS: depreciation charge	(4.83)
Income & Expenditure Surplus: as shown under IFRS (prior to one-off non-recurring costs)	**(2.14)**
- IFRS: impairment of PFI assets (one-off non-recurring cost)	(13.40)
Income & Expenditure Surplus: as shown under IFRS (after one-off non-recurring costs)	**(15.54)**

The Income and Expenditure surplus under IFRS (prior to one-off non-recurring costs) would have worsened by £4.60m. The impairment charge that we would have recognised under IFRS of £14.71m in 2008/09 would have been excluded from the calculation of the Financial Risk Ratings on the basis of the IFRS-compliant Compliance Framework for 2009/10.

£m	2008/09 Actual
Net Assets at 31 March 2009: as shown under UK GAAP	**173.66**
Adjustments to move from UK GAAP to IFRS	
- UK GAAP: take out residual interest	(5.35)
- UK GAAP: take out deferred asset	(18.65)
- IFRS: include PFI asset	95.11
- IFRS: include Finance Lease Creditor	(88.60)
Net Assets at 31 March 2009: as shown under IFRS	**156.17**

The table above shows that the overall impact on the Trust's balance sheet at 31 March 2009 is to reduce net assets by £17.49m.

2.3.3 Key Financial Assumptions

Income and Expenditure

Prior year performance and summary financial projections are set out below.

2008/09 Actual £m		2009/10 Plan £m	2010/11 Plan £m	2011/12 Plan £m
290.91	Income	301.80	308.42	311.50
(272.97)	Expenditure	(274.59)	(280.55)	(283.21)
17.94	**EBITDA**	**27.21**	**27.87**	**28.29**
(5.77)	PDC dividend	(4.78)	(4.78)	(4.78)
(7.13)	Depreciation	(9.75)	(9.35)	(9.95)
0.55	Interest/other finance expenses	(9.65)	(9.46)	(9.26)
5.59	**Total before non recurrent items**	**3.25**	**4.28**	**4.30**
(3.13)	Impairments	(2.50)	(2.50)	(2.40)
2.46	**Retained surplus/(deficit)**	**0.53**	**1.78**	**1.90**

The planned surpluses across the next three years will allow an increased investment in patient care facilities and equipment in line with Trust priorities, bringing forward the investment earlier than would have otherwise been possible.

Validation Checks

Within the key checks worksheet of the financial monitoring template, an adjustment of £0.6m is required on the validation rule that reconciles any movement on the income and expenditure reserve. This movement relates to the historic cost depreciation adjustment that occurs between the revaluation reserve and the income and

expenditure reserve. This adjustment is applied annually to match the benefit that accrues into the revaluation reserve over the life of an asset.

Income Analysis

The table below shows the planned and actual clinical income received in 2008/09 and the planned levels across the three-year period from 2009/10. The 2009/10 plans are based on the commissioned levels agreed with PCTs. They include activity growth (excluding inflation) of £3.86m in 2009/10 on the planned level of contract income with a further £3.58m and nil growth in 2010/11 and 2011/12.

Income	**Plan**	**Actual**	**Current Plan**		
	2008/09	**2008/09**	**2009/10**	**2010/11**	**2011/12**
	£m	**£m**	**£m**	**£m**	**£m**
NHS Clinical					
Elective, long-stay	13.87	13.10	14.28	14.42	14.56
Elective, short stay	9.44	8.92	9.93	10.03	10.13
Non-elective	83.35	84.85	88.37	91.02	91.93
Planned same day	19.12	21.56	23.76	24.47	24.71
Outpatients	36.20	37.10	31.38	32.11	32.43
Other activity	71.64	72.40	82.66	84.39	85.24
A&E	10.84	10.70	10.77	10.90	11.01
Sub-total	**244.45**	**248.62**	**261.15**	**267.34**	**270.01**
Non-NHS Clinical	**3.75**	**4.71**	**4.66**	**4.71**	**4.76**
Other	**32.86**	**37.22**	**36.00**	**36.07**	**36.73**
Total income	**281.43**	**290.91**	**301.80**	**308.42**	**311.50**

Significant features of the £10.89m increase between 2008/09 actual out-turn and 2009/10 plan includes:

- £4.43m of income growth related to the introduction of HRG Version 4
- Net inflation growth on the PCT contracts of £4.23m (1.7%)
- Reduction in PFI smoothing support from the Department of Health of £0.37m

The levels of planned clinical income for 2009/10 and 2010/11 are based on an assessment of the likely demographic changes over the period and the anticipated growth in services in line with the Trust's business strategy.

Tariff inflation is assumed at a rate of 1.7% (4.7% gross less 3% CRES) in 2009/10. Given the likely pressure on public spending for 2010/11 onwards, gross inflation is assumed to reduce to 3.5% (gross) and in line with the letter from Monitor to

Foundation Trusts issued on 2 March 2009, CRES is assumed at 3.5% and 4% for 2010/11 and 2011/12 respectively.

Operating Costs

The financial planning process for 2009/10 has included detailed assessment and prioritisation of the financial resources required to deliver the operational plans. Analysis was undertaken to ensure that pre-commitments, inflationary uplifts, cost pressures and any other external resource changes were identified and included in the overall financial plan. This included the detailed work undertaken to develop resource plans to deliver the projected activity growth. These plans have been subject to robust discussion and scrutiny to ensure that value for money is achieved. The Foundation Trust is also planning a number of qualitative developments in the year, in line with national and local priorities. These include developments around infection prevention and control and improving the quality of the hospital environment and other schemes to enhance patient outcomes and experience.

The Foundation Trust has also been subject (in line with the national tariff uplift) to 3.0% Cash Releasing Efficiency Savings (CRES) on contract income which equates to £7.54m in 2009/10.

The table below identifies how the operating expenditure of the Foundation Trust will change across the next three years.

Operating expenses	**Plan**	**Actual**	**Current Plan**		
	2008/09	**2008/09**	**2009/10**	**2010/11**	**2011/12**
	£m	**£m**	**£m**	**£m**	**£m**
Pay costs	(175.03)	(184.94)	(191.99)	(198.09)	(201.59)
Drug costs	(15.84)	(15.68)	(16.32)	(16.74)	(17.10)
Clinical supply costs	(22.01)	(21.89)	(22.88)	(23.29)	(23.59)
Other operating costs	(30.93)	(30.96)	(33.77)	(32.66)	(31.01)
PFI operating costs	(20.92)	(19.50)	(9.63)	(9.77)	(9.92)
Total	**(264.73)**	**(272.97)**	**(274.59)**	**(280.55)**	**(283.21)**

Operating costs have increased by £1.62m in 2009/10 compared to out-turn in 2008/09. The main reasons for this include:

- The impact of the accounting treatment of the PFI contract under IFRS which increases PFI costs as a result of taking out the UK GAAP transactions and then reduces PFI costs from the IFRS transactions (most of which are moved into 'finance costs' which are not included in the calculation of EBITDA)

- An increase in operating costs of £4.19m as a result of the additional clinical activity commissioned in 2009/10

- An increase in operating costs of £1.0m to further develop infection prevention and control and improve the quality of the hospital environment and other schemes to enhance patient outcomes

- Additional costs of £7.06m arising from national pay awards, agenda for change incremental drift, the cost of the consultant contract, the implementation of the European Working Time Directive and the impact of Non-Consultant Career Grade pay reform

- Inflationary pressures on non-pay costs of £2.65m

- Developments of £3.3m to ensure compliance with targets, national core standards, and legislative changes

- A reduction of operating expenses of £6.76m as a result of the CRES cost reduction programme across the Trust

The assumptions that were made around the likely impact of cost inflation across the various cost categories in 2009/10 were as follows:

- Pay costs expected to increase by 2.4% for staff paid under Agenda for Change terms and conditions

- Medical pay costs expected to increase by 1.5% in line with the 2009/10 pay award

- Drugs expenditure to increase by 1.5%

- Other costs to increase by 0.81%

The key planning assumptions for 2010/11 and 2011/12 are that Agenda for Change pay inflation is forecasted to be 2.25% and 1.5% respectively. Non-pay inflation is assumed to be at 1.5%. Other pay pressures resulting from Agenda for Change, Consultant Contract and Non-Consultant Career Grade pay reform are expected to increase costs by £1.8m in 2010/11 and £1.7m in 2011/12.

Non-operating Costs

The table below identifies the forecasts for non-operating items

Non-operating expenses	Plan	Actual	Current Plan		
	2008/09	2008/09	2009/10	2010/11	2011/12
	£m	£m	£m	£m	£m
Interest income	1.15	0.82	0.30	0.50	0.70
Interest/other finance expenses	(0.23)	(0.20)	(9.95)	(9.96)	(9.96)
Depreciation	(7.31)	(7.13)	(9.75)	(9.35)	(9.95)
PDC dividend	(5.77)	(5.77)	(4.78)	(4.78)	(4.78)
Impairment losses	(3.00)	(3.13)	(2.50)	(2.50)	(2.40)
Loss on asset disposals	0.00	(0.07)	0.00	0.00	0.00
Total	**(15.16)**	**(15.48)**	**(26.68)**	**(26.09)**	**(26.39)**

The main changes between 2008/09 out turn and 2009/10 planned non-operating items are:

- A reduction of £0.63m on interest received on cash balances as result of the fall in interest rates

- An increase of £0.11m on interest charges payable to the Foundation Trust Financing Facility

- A movement on the depreciation charge which comprises an additional £4.84m as a result of the PFI assets coming onto balance sheet as a result of IFRS and with the balance related to the change in valuation methodology adopted in 2008/09 and planned additions/disposals

- A reduction in the PDC dividend charge as a result of the change in the asset base (linked to the valuation methodology change mentioned above)

Fixed Asset Impairments

As part of the transfer of services from St. Luke's Hospital site at Huddersfield across the planning period, there will be fixed asset (buildings) impairments as accommodation blocks are vacated and are no longer in operational use. The value of impairments is offset against any positive revaluation reserve balances relating to that accommodation block and any remaining reduction in value is charged to the Income and Expenditure Account as a fixed asset impairment. As agreed with Monitor, and in accordance with the financial template issued by Monitor, these costs are excluded from the calculation of Financial Risk Ratings as they represent one-off non-recurring costs. The planned impairment charges to the Income and Expenditure across 2009/10, 2010/11, and 2011/12 are £2.5m, £2.5m and £2.4m respectively.

Consolidation of Charitable Funds

Under IAS27, we are required to consolidate charities where specific control tests are not met. All NHS Foundation Trusts have been granted a dispensation from HM Treasury from applying IAS27 to NHS charities until 31 March 2010. There are currently no firm plans to change the governance arrangements for Calderdale and Huddersfield NHS Charitable Funds, and as such, the control tests under IAS27 are likely to be met. Accordingly, the forecast financial position includes Charitable Funds in 2010/11 and 2011/12. The impact on the overall financial position and Financial Risks Ratings is not significant.

2.3.4 Phasing

Income is profiled equally across all four quarters. Activity modelling has indicated that in overall terms there is an expectation of little seasonal variation. Quarterly profiling has been incorporated within the model for individual CRES schemes and any significant service developments to reflect planned start dates. Pay costs have been profiled to take account of incremental dates. Non-pay costs have been profiled equally across all four quarters in line with clinical income.

The capital investment programme is profiled according to the expected spend profile of each of the individual schemes. The forecast movement on working capital balances is based on trend analysis to reflect anticipated seasonal profiles, as well as specific known issues where material. For example, historically we have always seen a reduction in NHS debt in the second half of the year as forecast trading activities are firmed up and liabilities settled.

2.3.5 Investment and Disposal Plans

Three-year Capital Programme

The Board of Directors has established a three-year capital investment programme which reflects the key strategic and operational priorities of the Trust. The tables below sets out, in summary, the capital investment planned for the next three years.

	2009/10	2010/11	2011/12
	£m	£m	£m
Funding			
Use of internal resources	4.46	7.02	3.53
Depreciation	9.75	9.35	9.95
Loans	1.20		
Foundation Trust Financing Facility - Loan repayment	(0.28)	(0.56)	(0.56)
PFI Finance Lease Creditor - Lease repayment	(1.47)	(1.59)	(1.21)
Total	**13.66**	**14.21**	**11.71**

	2009/10	2010/11	2011/12
	£m	£m	£m
Schemes			
Operational Capital Schemes	2.64	2.70	1.37
Strategic Investments	3.74	3.00	3.50
Infrastructure Schemes	7.28	8.50	6.85
Total	**13.66**	**14.21**	**11.71**

The original capital programme for 2008/09 was £18.99m; actual capital expenditure for the year was £11.49m. There were a number of specific schemes where actual expenditure is less than plan. Notably, the replacement of the boiler house at Huddersfield Royal Infirmary was behind plan due to the need to revisit the options appraisal as a result of the change in energy prices. In addition, the replacement of the endoscopy unit at Calderdale Royal Hospital also did not progress in line with original plans in order to ensure the design solution met all relevant quality and environmental standards. The resources for these two schemes have been carried into 2009/10, and both schemes are scheduled for commencement in 2009.

Major capital schemes included within the three-year capital programme include:

- The re-provision of the endoscopy unit at the Calderdale Royal Hospital in 2009 to delivery additional capacity and ensure that all relevant accreditation and quality criteria are fully met (£4.7m)

- The replacement of the coal-fired boiler house at Huddersfield Royal Infirmary to deliver energy efficiency and to meet carbon reduction targets (£4.8m)

- The replacement of the paediatric assessment and observation unit and the endoscopy unit at Huddersfield Royal Infirmary to deliver enhanced patient care facilities (£7.5m)

- A programme of major and minor ward upgrades and refurbishments at Huddersfield Royal Infirmary (£7.8m)

Asset Backed Investment Vehicle

The Trust, in considering its future capital requirements and service, financial and estates strategies, is exploring a range of options for future investments, the use of surplus estate and the development of Acre Mill.

A project has been established to consider the following over the next 12/18 months:

- To ensure that as the land and buildings have further development potential that the option of straight forward disposal is tested against a joint venture for value for money;
- To assess expected risk and returns of any investment decision;

- To ensure appropriate internal structures required to deliver the investment decision are in place; and
- To assess any effect the investment will have on the Trust's financial position, in particular its Financial Risk Rating;

The project plan will follow Monitors guidance on Risk Evaluation for Investment Decisions by NHS Foundation Trusts (REID).

The Trust has identified the following as key outcomes which will need to be delivered by the preferred solution:

- Support for the achievement and delivery of the Trust's vision, business and service strategy
- Delivery of the optimal return on surplus land and buildings which will address and support the Trust's longer term funding requirements for capital investment
- Utilisation of the surplus estate to finance the development of key strategic assets e.g. Acre Mill
- Minimal impact on the Trust's financial risk rating
- Promote creativity and innovation in estate utilisation

In line with Treasury's approach as set out in 'Infrastructure procurement: delivering long term value' (March 2008) and 'Joint ventures: A guidance note for public sector bodies forming joint ventures with the private sector' (January 2009), the following has been taken into account in considering the accounting treatment for the Trust's approach to this investment opportunity.

- This guidance will be taken along side further independent legal, financial and technical advice throughout the project

- The purpose of considering a Joint Venture (JV) arrangement is to leverage long-term value from the surplus assets of the Trust and to ensure that every reasonable step is taken to maximise the value of surplus land and other benefits. Only if this is greater than a simple disposal on the open market will this option be pursued

- The way in which assets and liabilities of the JV are recorded by the Trust will depend on the Trust's relationship with the private sector which has yet to be determined

- Ownership and control of a JV body is assumed to be 50/50 with neither JV partner having overall control. Accounting standards require it to be classified as private sector investment which should be held at fair value

As this project is still in the early stages of development, the assumption within the three-year financial projections is that the buildings on the St Luke's Hospital site will be impaired to nil as they are vacated and taken out of operational use. This will occur

in 2009/10, 2010/11 and 2011/12. The financial projections assume a sale value of c.£20m (latest assessed market value).

2.3.6 Loans and Working Capital

Working Capital Facility

The Trust will maintain an approved committed working capital facility across the three-year planning period. The current approved facility is set at a level of £18m (equivalent to approximately 24 days of operating costs). The Trust has not utilised any working capital facility since authorisation as a Foundation Trust and has no plans to do so over the next three years covered by this plan.

Loans

In 2007/08 the Trust entered into a loan agreement with the Foundation Financing Facility (which is part of the Department of Health) for £7.6m. The Trust has no other external repayable loans. This loan agreement is to fund specific capital schemes relating to replacing infrastructure on the Huddersfield Royal Infirmary site e.g. electrical mains and lifts. In 2007/08 and 2008/09 the Trust drew down £2.1m and £4.3m respectively of that loan agreement. The remainder of the loan will be drawn down in 2009/10. The Trust has no current plans to take out additional loans.

Prudential Borrowing Code

The Trust has an obligation to stay within the requirements of the Prudential Borrowing Code (PBC) set by Monitor. The PBC was revised and issued on 1 April 2009. Following the adoption of International Financial Reporting Standards from 1 April 2009, and the bringing of PFI-funded schemes onto the balance sheet, Long-Term Borrowing Limits are now determined by a two-tier system. Tier 1 limits are set by Monitor for Foundation Trusts based on their annual plans and in accordance with the ratios contained in the PBC. Tier 2 limits are available to accommodate affordable 'major investments' including PFI schemes. The Trust has a binding commitment in relation to a PFI scheme; this causes the Tier 1 limits to be breached. In line with the PBC, the PFI scheme will therefore be 'grandfathered' in. This will lead to a Tier 2 limit being set by Monitor at the level of total borrowing (including commitments) as at 1 April 2009.

Whilst the calculation of the Prudential Borrowing Limit is undertaken by Monitor on an annual basis based on it's assessment of the financial projections contained in this annual plan, analysis undertaken by the Trust suggests that two of the four PBC ratios will exceed the Tier 1 limits but will be within the Tier 2 overall cap. The Trust expects Tier 2 limits in these ratios to be 'grandfathered' in accordingly.

2.3.7 Cost Improvement Plans

Cash-releasing efficiency savings (CRES)

The Foundation Trust's overall plan for 2009/10 based on the 3% reduction in PCT contract income requires cash-releasing efficiency savings of £7.54m. This CRES target has been devolved to the Divisional management teams to deliver. The key areas included within CRES plans are:

	CRES £m
Clinical and Operational Divisional efficiencies incorporating LEAN methodology and Better Care, Better Value indicators: • continued delivery of procurement savings; • income generation schemes; • driving efficiencies in length of stay and improving patient flow; • reducing outsourcing of clinical activity;	4.70
Improved contributions relating to service re-design & efficiency: • delivery of medicines management savings; • skill-mix efficiency and productivity reviews	2.07
Increased contribution from income growth	0.77
TOTAL	**7.54**
Recurrent	***7.54***
Non-recurrent	***0.00***

All divisions have developed plans to achieve their savings target and they have been subject to review and discussion by Directors. The organisation has a strong track record of CRES delivery through the devolved divisional structure and the divisional CRES plans have strong and clear clinical and managerial ownership. Plans include income generation schemes through expanding clinical service provision, for example outreach services at Todmorden Health Centre.

Delivery against targets will be performance managed through the monthly Divisional Finance and Performance meetings. If CRES plans do not come to fruition within the planned timescale or at the planned value, further initiatives will be identified in-year or existing initiatives will be brought forward.

The CRES targets for 2010/11 and 2011/12 are £9.14m and £11.0m respectively. Plans to deliver these targets are currently being developed and will continue to focus on the areas detailed above. In addition, the Trust is in the process of starting an organisation wide review of efficiency and effectiveness, using measures such as the

NHS Better Care, Better Value indicators as well as external consultancy support, to ensure that clinical services continue to flourish in challenging economic times.

3 RISK ANALYSIS

3.1 Governance Risk

Governance Commentary

This commentary describes our ability to comply with the governance requirements outlined in the Compliance Framework. The seven elements are:

- **Legality of Constitution**

  There were no significant changes in the constitution in 2008/09, and none are planned for 2009/10.

- **Growing a Representative Membership**

  In 2008/9 the Foundation Trust has focussed on building a clearer picture of our membership by working closely with our health informatics service. Ensuring the data on membership is robust and up to date gives us a firm foundation for our recruitment activity. Our challenges continue to be associated with attracting younger members and those from the South Asian communities but new relationships and networks have been formed that again should serve to narrow the representation gap in the future.

- **Appropriate Board Roles and Structures**

  Following the resignation of Graham Caddock a new Non-Executive Director, Jane Hanson was appointed by the Membership Council during 2008/09 and she took up post in October 2008. Two other Non-Executive Directors, Carol Clark and Bill Jones, had their terms of office reviewed and both were reappointed for two and three years respectively. The Board of Directors continues to hold public meetings on a monthly basis, whilst the Membership Council meets on a quarterly basis.

  The Membership Council has considerable active involvement in the affairs of the organisation, and in supporting the development of Trust policy.

  The term of office of one Non-Executive Director is due for review in November 2009 and arrangements are in hand for this to be reviewed.

  The Board of Directors is supported by the Audit Committee, which provides it with assurance that it is meeting its corporate and clinical governance obligations.

  The development of both the Board of Directors and the Membership Council is on-going, supported by workshops, away days, joint sessions and informal get

togethers. Building productive relationships and ensuring clarity around the responsibilities of the two functions is critical in supporting effective governance.

- **Service Performance (Targets and National Core Standards)**

  Compliance with targets and National Core Standards is monitored by the Board of Directors on a monthly basis, through the performance report and, separately, via the Assurance Framework. When challenges are foreseen, mitigating actions are put in place to deal with them.

  The Board of Directors has declared compliance with all of the National Core Standards during 2008/9.

- **Clinical Quality**

  The Patient Safety Committee monitors the safety and quality of clinical services on behalf of the Board of Directors. Assurance is obtained from a monthly report on Key Performance Indicators and from a quarterly report on Learning from Experience, aggregated data which provides information on patient experience.

  Our involvement in the Safer Patients Initiative continues, and we have many frontline staff involved in work to change practice, using LEAN and SPI methodologies. These are demonstrating measurable improvement to patient safety and quality of service.

  We have established a community wide HCAI Steering Board and sub-groups to oversee our HCAI action plan implementation, and ensure improvements across the whole community in acquired infections. This Board has CEO and director level representation from both local PCTs as well. There is absolute commitment from all partner organisation to work together to reduce MRSA bacteraemias and Clostridium difficile infections.

- **Effective Risk and Performance Management**

  The Foundation Trust has effective risk and performance management frameworks, which are “operationalised” through the Clinical Management Structure and Corporate Teams.

  The Audit Committee provides ongoing assurance to the Board of Directors regarding the effectiveness of the System of Internal Audit, which informs the Annual Statement of Internal Control.

  All recommendations to the Board of Directors from the Audit Committee are dealt with in a timely way.

- **Effective Contract Management**

  The Trust has a senior team responsible for contract negotiation and management. 2009/10 sees us moving onto the new standard contract which

encompasses the changes in coding and the tariff associated with HRG 4. CHFT has put new systems in place to ensure rigorous monitoring of the new contract. There is already a well established and effective contract management system in place with local PCTs, and this will be developed to ensure that no organisations are left at risk.

- **Co-operation with NHS bodies and Local Authorities**

  The Foundation Trust has effective working relationships with other NHS organisations in the local health economy, and is an effective member of wider clinical networks. We are a full member of the two Local Strategic Partnerships.

  We have established a regular meeting of senior managers, including colleagues from Social Services, who meet to ensure that the whole Health and Social Care system is running smoothly. This is in place with both local PCTs and their respective local authority colleagues.

Significant Governance Risks

The Board of Directors is responsible for the management of key risks. The Board receives details of risks through regular board reports. The key risks and mitigating actions are presented below.

RISK	RISK RATING	MITIGATING ACTIONS
The Trust fails to meet its target for the incidence of MRSA bacteraemia	15	Infection control policies/ procedures. Saving lives HII. Strengthened performance management arrangements. Well resourced Infection control Team. Partnership working with PCTs to influence a reduction in community acquired MRSA. MRSA screening for elective and emergency in-patient
The FT Fails to meet its target for incidence of C Difficile	25	Infection control policies/procedures Saving lives HII Strengthened performance management arrangements Well resourced Infection Control Team
The change to the out of hours Primary Care Emergency Care Provider, could impact on A&E attendances and the 4 hour wait target.	15	Negotiations with PCT to ensure there is sustained improvement in their provider's performance. Emergency Care Collaborative. performance management

RISK	RISK RATING	MITIGATING ACTIONS
Reduction of the resources needed necessary to ensure sustainability of current performance against the18 week target	10	Divisional plans in place, monitored by the Planned Care Board
Risk of failing to meet cancer targets: - The actual performance targets have not yet been announced. Pressure points in lung and head and neck pathways	15	Performance overseen by Planned Care Board. Pathway Group continues to apply "no delay improvement methodologies".
Delay in achieving long term solutions to the environment issues on some wards, particularly at HRI, due to the restricted availability of decant facilities. These could be further restricted as the bed base is further reduced, as we meet the requirements on mixed sex accommodation.	20	Estates strategy. Capital plans. Planned maintenance. Structured inspections to ensure that short term solutions continue to be achieved.
Risk of failing to meet the requirements on mixed sex accommodation, within the set timescales, due to the amount of infrastructure work required	15	Option appraisal completed. Action plan in place.
The risk of swine flu developing into a pandemic, threatening the FT's ability to deliver services	25	National, Regional and local (tested) pandemic flu plans are in place

- **Proposed Governance Risk Rating**

The Trust proposes a governance risk rating of **Green**, reflecting the submission in section 3 of complete and satisfactory self-certification on risk and performance management, on board roles, structures and capacity, and on compliance with authorisation.

- **HCAI Targets**

Following the HCC inspection against the Hygiene Code the Trust has made improvement in a number of focused areas alongside existing infection prevention and control priorities during 2008/09.

The sustained commitment to these areas of work and continuous improvement has culminated in a significant reduction in our MRSA bacteraemia and Clostridium difficile rates.

TARGET		Q1	Q2	Q3	Q4
MRSA	2008/9 target	7	12	16	19
	2008/9 actual	4	6	7	12
	2009/10 target	7	12	16	19
C.DIFFICLE	2008/9 target	50	98	144	188
	2008/9 actual	44	85	126	167
	2009/10 target	51	92	130	166

3.2 Mandatory Services

- **Risk Rating**

At this time there are no anticipated changes to Mandatory Services for 2008/9 and the Trust considers its risk rating in this area to be **Green.**

- **Disposal of Assets**

There are no disposals of protected assets planned and no protected assets have been declassified.

- **Changes to Mandatory Goods and Services**

The Trust has reviewed the schedule for mandated goods and services and has identified the following significant re-categorisations of existing services:

- Direct Access referrals from GPs for Pathology Services have been included within the schedule for the first time to represent this high volume service
- Direct Access referrals from GPs for Radiology Services have been included within the schedule for the first time to represent this high volume service
- Direct Access referrals from GPs for Phlebotomy Services have been included within the schedule for the first time to represent this high volume service
- Obstetric Services – following a review of antenatal admissions not related to admission, there has been a re-categorisation between obstetric emergency spells and ward attendees
- Outpatient Procedures – due to the introduction of HRG4 and the recognition of outpatient procedure coding, a planned same day tariff has been developed, resulting in a re-categorisation between outpatient attendances and outpatient procedures
- Midwifery Outpatient episodes – there has been a re-categorisation of midwifery led outpatient attendances

A summary of the top five increases and decreases in service provision are also described below:

- Due to the work being undertaken to deliver the NHS and Social Care Long Term Conditions Model within Primary Care, there has been a plan to decrease the contracted level of emergency spells
- The Calderdale Musculoskeletal See and Treat Service commenced in September 2008 and is represented as a full year's activity within the plan
- There has been an increase in the activity within Dermatology Outpatient services
- Day case treatments in Plastic Surgery have been delivered on the Huddersfield Royal Infirmary site from September 2008 and are represented as a full year's activity within the plan
- There has been a fall in demand and activity within the neonatal unit, though this is not expected to be a sustained reduction

3.3 Financial Risk

3.3.1 Commentary on Financial Risk Rating

Based on the Compliance Framework for 2009/10, the Trust's self-assessment based on the financial projections within the plan is as follows:

	2009/10 Plan	2010/11 Plan	2011/12 Plan
EBITDA margin (%)	4	4	4
EBITDA (% last achieved)	5	5	5
Return on assets (%)	3	4	4
I&E surplus margin (%)	3	3	3
Liquidity (days)	4	3	4
Rating	**4**	**4**	**4**

3.3.2 Significant Risks

There are a number of potential financial risks for 2009/10 which have been identified and that will be subject to close monitoring and management.

The following contains an assessment of the potential financial impact, likelihood and the measures taken to mitigate against them.

Risks and Likelihood	Potential impact	Mitigating action and residual risk
The Foundation Trust fails to deliver the £7.54m planned CRES programme (Medium Risk)	£1.51m (20% of full year value) – based on previous successful track record of delivery	• CRES plans were developed and agreed prior to the start of the financial year • Divisional Management Teams have been responsible for ensuring that Divisional CRES plans are realistic and achievable • Robust performance management is undertaken on delivery of CRES schemes through the monthly Divisional Finance & Performance meetings • The Board of Directors and Executive Board receive regular report on CRES delivery • Further CRES schemes would be developed immediately once any slippage/non-delivery became apparent
Budget holders are unable to contain expenditure within their budgets (Low Risk)	£2.73m (1% of operating costs budget) – based on	• All Divisional priorities have been considered as part of a robust and inclusive planning process • All activity developments have been scrutinised to ensure that sufficient resources are made available to deliver changes in

Risks and Likelihood	Potential impact	Mitigating action and residual risk
	track record of successful delivery	commissioned levels of activity • Budget-holders have the levels of financial management awareness and support to ensure that they remain within budget • Active monthly monitoring via the Finance & Performance meetings and the Trust Executive Board/Board of Directors of the in-year financial position
Clinical activity levels increase with an associated increase in costs, and the PCTs do not pay for the work (Low Risk)	£ 2.61m (1% of NHS clinical income)	• The Contract with the PCTs will be enforced
Clinical activity levels drop below plan which leads to less income under PBR and the Trust is unable to reduce or flex capacity to reduce its cost-base (Low Risk)	£2.61m (1% of NHS clinical income)	• The view of the Foundation Trust is that clinical activity is unlikely to decrease below planned levels, based on past trends, demographic changes in the population as well the impact of the economic down-turn on demand for secondary care services • Variances to planned clinical income will be presented against Divisional financial positions, and it is clear to Divisions that any under-trade in activity (and income) will require reductions in capacity (and costs)
Costs increase more than the inflationary pressures built into the financial plan (Medium Risk)	£1.0m	• Regular monitoring of the Foundation Trust's costs and variances against key cost categories • Further CRES in-year should the risk become material will be developed
A loss of income related to non-achievement of CQUIN targets or through contract penalties (Low Risk)	£0.8m (based on 25% of planned 2008/09 CQUIN funding and £0.5m of 'contract risk')	• Whilst the CQUIN targets present some challenges, the Trust is confident that these will be achieved • Action plans have been developed to ensure achievement against targets • Close monitoring of performance against plan/targets will be undertaken by the Executive Board and Board of Directors

The table below summarises the downside scenarios and the resultant impact on the Trust's financial risk rating.

Scenario	Financial impact	Overall financial risk rating
Submitted annual plan – base case	-	4
Failure to deliver full CRES target	£1.5m	3
Budget holders unable to contain expenditure within budget	£2.73m	3
Clinical activity increases over plan and PCTs do not pay	£2.61m	3
Clinical activity fall below plan and Trust cannot reduce cost-base	£2.61m	3

3.4 Risk of Any Other Non-Compliance with Terms of Authorisation

None identified.

4 DECLARATIONS AND SELF-CERTIFICATION

4.1 Board Statements

Risk and Performance Management

The Board of Directors confirms that:

Clinical Quality
The board of directors is required to confirm the following:

☑ The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), its NHS Foundation Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients;

☑ The board will self certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

Service Performance
The board of directors is required to confirm the following:

☑ The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards, and a commitment to comply with all known targets going forwards.

Risk Management
The board of directors is required to confirm the following:

☑ Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;

☑ All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned.

☑ The necessary planning, performance management and risk management processes are in place to deliver the annual plan.

☑ A Statement of Internal Control ("SIC") is in place, and the NHS Foundation Trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to most up to date guidance from HM Treasury (www.hm-treasury.gov.uk); and

☑ The Trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit; and

☑ All key risks to compliance with the Authorisation have been identified and addressed.

Compliance with the Terms of Authorisation

The board of directors confirms that:

☑ The board will ensure that the NHS Foundation Trust remains at all times compliant with its Authorisation and relevant legislation;

☑ The board has considered all likely future risks to compliance with their Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and

☑ The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with the Authorisation.

Board roles, structures and capacity

The board of directors confirms that:

☑ The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;

☑ The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability;

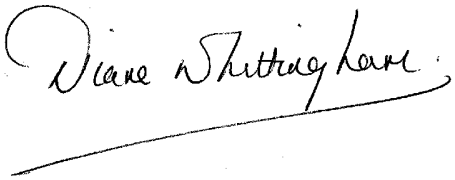
☑ The selection process and training programmes in place ensure that the non executive directors have appropriate experience and skills;

☑ The management team has the capability and experience necessary to deliver the annual plan; and

☑ The management structure in place is adequate to deliver the annual plan objectives for the next three years.

Commentary in absence of full self-certification:

Not applicable



Signature ……..

Diane Whittingham in capacity as
Chief Executive and Accounting Officer

Signature ……

Sukhdev Sharma in capacity as
Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the Membership Council.

5 MEMBERSHIP

5.1 Membership Report

Membership size and movements

Membership Size and movements		
Public Constituency	**Last year (2008/09)**	**Next year (estimated) (2009/10)**
At year start (April 1)	7,907	9,306
New members	2,099	917
Members leaving	700	824
At year end (March 31)	9,306	9,399
Staff constituency	**Last year (2008/09)**	**Next year (estimated) (2009/10)**
At year start (April 1)	1,197	1,637
New members	580	2,078
Members leaving	140	191
At year end (March 31)	1,637	3,524
Patient constituency	**Last year (2008/09)**	**Next year (estimated) (2009/10)**
At year start (April 1)	NOT APPLICABLE	NOT APPLICABLE
New members	NOT APPLICABLE	NOT APPLICABLE
Members leaving	NOT APPLICABLE	NOT APPLICABLE
At year end (March 31)	NOT APPLICABLE	NOT APPLICABLE

Analysis of current membership

Total membership by age compared to eligible catchment population (eligible catchment population refers to all those in the catchment area over the age of 16).

Analysis of current membership		
Public Constituency	**Number of members**	**Eligible members**
Age (years):		
0-16	24	9588
17 – 21	675	43116
22+	8607	508342
TOTAL		561024
Ethnicity:		
White	8543	506690
Mixed	76	3709
Asian or Asian British	496	43354
Black or Black British	156	5617
Other *	35	1654
(Unknown) *		
Socio-economic groupings:		
ABC1	4604	264412
C2	1433	91579
D	1756	113546
E **	1513	91487
Gender analysis		
Male	3735	267274
Female	5571	293750
TOTAL		
Patient constituency	**Last year (2008/09)**	**Next year (estimated) (2009/10)**
NOT APPLICABLE	NOT APPLICABLE	NOT APPLICABLE

Election Turnout 2008

Date of election	Constituencies involved	Number of members in constituency	Number of seats contested	Number of contestants	Election turnout %
October 2008	1	546	1	2	27.8%
"	2	1829	1	4	23.5%
"	3	1174	1	1	Uncontested
"	4	319	1	1	Uncontested
"	5	1047	1	2	30.9%
"	6	624	1	3	22.8%
"	7	1252	2	3	18.1%
"	9	135	1	1	Uncontested
"	13	358	1	1	Uncontested

5.2 Membership Commentary

- **Constituencies**

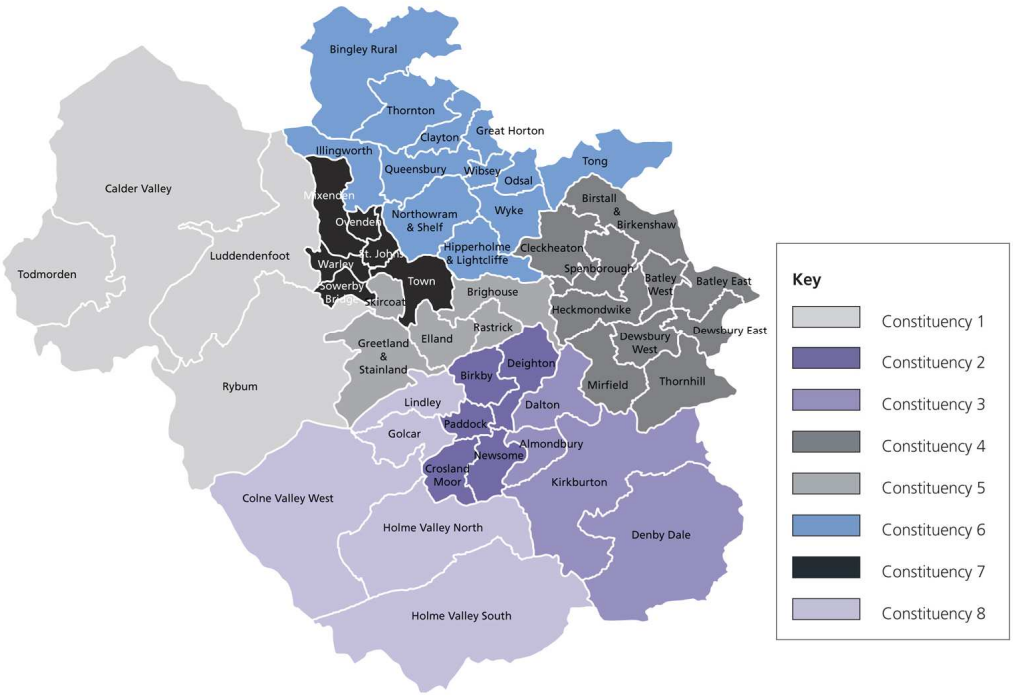
The Trust has two membership constituencies

- A "Public" Constituency
- A "Staff" Constituency

It does not host a "Patient" Constituency

a. **The Public Constituency**
The public constituency of the Trust consists of eight constituency classes based on the electoral wards of Calderdale and Kirklees and South and West Bradford. Eligibility is for people who are 16 years and over. Each constituency has two elected public members, making 16 public members in total.

Our catchment area is:



The Constituencies have been chosen to reflect patient flows into the Trust. The majority of our patients come from Calderdale and South Kirklees but the Trust also provides services across North Kirklees and on our boundaries with Bradford. In 2008/9 the Trust continued to build on its ambition to provide more care closer to home. The opening of the new Health Centre in Todmorden is likely to have an impact on patient flow and this will be closely monitored in 2009/10 to ensure that our membership boundaries are reflective of the populations that we serve.

b. **The Staff Constituency**

The staff constituency is divided into five constituency classes, which cover the following staff groups:

9 - Doctors and dentists
10 - Allied health professionals, healthcare scientists and pharmacists
11 - Management, administration and clerical
12 - Ancillary
13 - Nurses and midwives

There are six elected staff members, one from each of constituencies 9 to 12 and two from constituency 13 to reflect the size of this group.

Changes in Membership

- **Public Membership**

As can be seen from the Membership Report during 2008/9 public membership has increased in line with the plan. The Membership Office continues to pay attention to maintaining and cleansing the database which we manage in-house. Good quality data supports effective decision making and productive working relationships with the membership.

- **Staff Constituency**

The Trust to date has had an “opt in” membership regime for staff. During 2007/8 the Membership Engagement, Recruitment and Retention Sub Committee recommended to the full Membership Council that new staff should automatically be registered as Foundation Trust Members with the “opt out” option. Further work will be undertaken this year to take forward a full “opt out” process for all staff. As can be seen from the Membership Report during 2008/9 staff membership has increased in line with the plan taking into account staff turnover.

- **Plans to Develop a Representative Membership**

The Trust aims to attract a membership that is representative of the public it serves in terms of age, ethnicity, socio-economic profile and gender. The Trust has focused its recruitment activity to attract the under represented population. It will be noted that although there are still some shortfalls in relation to the 16-21 years the percentage is increasing.

With regard to the ethnic representation of the membership, the main discrepancy lies in the Asian/Asian British category, with the Trust attracting 5.3% of its total membership in this group against an eligible population of 7.76%.

- **Membership Plan 2008/09**

The past 12 months has seen recruitment activity which was aimed at addressing the issue of equitable representation and developing the membership.

The activity has included visits to job fairs, fresher's days, shopping centres, mosques and colleges. All these events have been supported by our membership councillors. They have been able to meet with the public, listen to their views and share information about the Trust.

Attendance at these events has had an impact on under-represented groups. Whilst on occasions the numbers of recruits may have been small, it has enabled us to widen our network and develop partnerships. We have continued to maintain and build on our relationships with colleges and universities and in addition have established links with voluntary organisations in both towns.

- **Membership Plan 2009/10**

The recruitment plan for 2009/10 is based on our Membership Strategy. The Membership Council via the Membership Engagement, Recruitment and Retention Sub-committee has agreed to maintain a small increase in membership over and above the level of membership losses and to target recruitment in a focused way towards the under-represented groups in the community as outlined above.

The key objectives include:

- Develop a constituency for "members in waiting" by engaging with the local authority Youth Parliament.
- Consider the development of associate membership for 'out of area' members.
- Continue to engage with colleges and universities, providing them with an insight into their local Foundation Trust and the wider NHS.
- Utilise knowledge and the skills of the Muslim chaplaincy services to enable engagement with under represented populations.
- Build on the work with local authorities and voluntary agencies to enable interaction with under-represented groups and constituencies.
- Continue to capitalise on the skills of the membership council using their established contacts and networks.
- Target community events to share information about Calderdale and Huddersfield NHS Foundation Trust, aiming to make membership meaningful.
- Develop relationships with our local children's centres.

- **Engagement Activities 2008/9**

- The role of the Membership Council is to ensure that the Trust responds to the needs and preferences of the local community as well as working towards achieving a representative membership to ensure all sections of the community have a voice. Membership Council members have focused on engaging with the membership to hear their views on local services.

- A bi-monthly Medicine for Members event, hosted by Membership Council members and featuring clinicians from the Trust speaking on topics of local and national importance has proved very popular and consistently attracts between 50 and100 members. This has resulted in presentations around the topics of Elderly Care, You and Your Eyes, Cardiology, Rheumatology, Anaesthetics and Pain Control. Nursing in the 21st century included a visit to the Skills Laboratory at Huddersfield University which proved popular with by our younger members. All events were hosted by our Membership Council members and evaluated extremely well.

- As the local LINks continue to develop, we have held a number of joint workshops to clarify the different roles and responsibilities of the Membership Council and the two local LINks. Together we have worked on specific issues including audiology, maternity and rehabilitation services.

- Members with an interest in specific services have been invited to focus groups which are linked to our clinical divisions. These are held twice a year for each of the five divisions and inform both divisional and trust plans. Members have the opportunity to hear service plans and have their views heard in order to help shape future services.

- The Membership Council members are linked to our clinical divisions and host the focus groups. At divisional reference groups they hear about divisional business and share their views and that of the wider membership. Regular feedback is given to members at the focus groups with regard to issues that have been raised at earlier events.

- The unitary AGM was held alongside a small health fair where Membership Council members and the Board of Directors engaged with the membership and the wider public.

- A healthcare event was held for profoundly deaf people. They were invited to discuss accident and emergency Services in relation to provision of support for profoundly deaf people.

- We have undertaken a survey of membership with a view to improving membership services and support involvement. The results are due by the end of May. This will become part of our annual cycle of engagement activities.

- The Trust continues to write and publish a newsletter three times a year informing members of the latest healthcare reports on membership events and a programme of future membership activities.

- Attendance at an “Understanding Islam” day in a local mosque provided an opportunity for staff and the Membership Council to both engage and recruit members from an under represented community.

- For staff members we have started a quarterly event under the banner of “A conversation with the Chief Executive” which has been well received. The aim is to engage the staff in future strategy and to build their views into our plans.

- **Engagement Plans 2009/10**

  - Continue to build on the success of the focus groups and increase participation.
  - Develop a systematic approach to feedback to the membership following the focus groups.
  - Continue to develop the Medicine for Members Programme incorporating departmental visits.
  - Engage with the Youth Council, schools and colleges to elicit their information and involvement needs and understand how best we can work with them.
  - Utilise the membership in a wider range of activities such as reviewing leaflets, recruitment of staff and service specific focus groups.
  - Expand the health fair at the unitary AGM, involving all the divisions to provide pertinent information on displays to showcase their services. Allowing for wider member engagement with increased information.
  - Continue to develop staff engagement events.

- **Co-ordinating our Activities**

  The key forum for all membership recruitment and engagement activities is the Membership Engagement, Recruitment and Retention Group. This is chaired by a Membership Council member and each divisional reference group chair sits on the group to ensure that messages from members are co-ordinated and prioritised. This group produces a report for the Membership Council on the outcome of membership recruitment and engagement activity for the attention of the Board of Directors.

  At the membership events held in 2008/9, including the 10 focus groups key themes emerged:

  Members were very positive about:

  - The move towards care closer to home for consultations and diagnostics.
  - Improvement in infection rates
  - Continuity of care
  - The repatriation of services from tertiary centres
  - New facilities
  - The increase in Matrons and nursing establishments
  - The involvement of patients in the management of long term conditions
  - The user-friendliness of consultant medical staff
  - Improvement in waiting times

- The focus on quality

Members would like the Trust's plans to pay attention to:

- Better patient information on all areas of care and service delivery – explore use of DVDs and new technologies.
- Regard for service users and their families with disabilities of all kinds.
- Continued focus on privacy and dignity including eliminating mixed sex accommodation.
- Improved communications about care between professionals, sites and agencies.
- Focus on improved discharge planning.
- More regular information to the public on successes, new facilities, new services.
- Educating the public, including children, on health related issues.
- Continued improvement in waiting times.
- Attention to getting the basics right as well as developments.

- **Election of Membership Council Members 2008**

All elections are held in accordance with the election rules as stated in the Constitution. The Trust will continue to retain the service of Electoral Reform Services Limited. During 2007/8 the following seats became vacant:

Public Constituencies
- One seat - Constituency 1
- One seat - Constituency 2
- One seat - Constituency 3
- One seat - Constituency 4
- One seat - Constituency 5
- One seat - Constituency 6
- Two seats - Constituency 7

Staff Constituencies
- One seat - Constituency 9
- One seat - Constituency 13

New Membership Council members took up their seats following the Annual General Meeting held on the 1 October 2008. One of the eight public seats and both of the two staff seats went to existing Membership Council members, demonstrating their commitment to the role.
All appointments were made on a three-year term to complete in October 2011.

- **Board Assurance**

The Board of Directors confirms that elections were held in accordance with the rules stated within the Trust's Constitution. This is verified in the election report of 11 September 2008 as follows:

"The elections were conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and ERS is satisfied that these were in accordance with accepted good electoral practice."

Christy Gerould
Returning Officer, ERS
On behalf of Calderdale & Huddersfield NHS Foundation Trust.

- **Election of Membership Council Members 2009**

Because of staggered appointments put in place when the Trust was granted Foundation Trust Authorisation (August 2006), the following seats fall vacant during 2009/10

Vacancies during 2009/10

Public Constituencies
- One seat - Constituency 3
- One seat - Constituency 4
- One seat - Constituency 5
- One seat - Constituency 6
- One seat - Constituency 8

Staff Constituencies
- One seat - Constituency 10
- One seat - Constituency 11
- One seat - Constituency 12
- One seat - Constituency 13

- **Promoting Elections**

The Trust will continue to work to promote its annual elections and to encourage greater interest and turnout. It will:

- Work with Electoral Reform Services (the Trust's independent scrutineers) to adopt fair electoral rules that encourage participation of all active members.

- Maintain guidelines for running elections, including policies on canvassing, election expenses and election material.

- Work with local media and other organisations (such as local councils) to feature elections and the public member role in newspaper, magazine and radio media.

- Organise election briefing opportunities for members who are potential Membership Council candidates.

- Ensure all members are fully informed about elections and the opportunity to become a Membership Council member.

- Encourage representation from the constituencies where members have been less active to ensure all places on the Membership Council are filled.