

Annual Report and Accounts 2014/15



Calderdale and Huddersfield NHS
Foundation Trust

Annual Report and Accounts

2014/15

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

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Cover picture

Ieuan Jones, 21, is a healthcare science apprentice and joined the Trust in September 2014. Ieuan from Copley, Halifax, is hoping to use his experience with the Trust to go to University to study medicine.



Chairman's Statement / Overview

- Outpatient Services
Macmillan Unit
- Wards

Ground

- Outpatient
Blood Test
Cardiology
Chest Clinic
Dermatology
Diabetes Centre
General Outpatients
Head & Neck Unit
Ent/Audiology
Eye Clinic
Oral Surgery
- Pathology
Pharmacy
Renal Dialysis Centre
Social Services
Urology Investigation Unit

- ☕ Café
- ☕ Refreshments (L)
- || Restaurant (Ingl)
- ☎ Public Telephone
- ♿ Toilets

First Floor

- Outpatient Services
- Outpatient Services
- Outpatient Services



Chairman's statement



I want to start this report with a look back at a real year of achievement for this Trust set against a background of extremely tough and challenging times faced by everyone in the NHS. The toughest, I have to say, since I became Chairman four years ago.

Quite simply, it has been a year of great challenges – and in this we are not alone. Nationally the NHS is undergoing a period of huge and rapid change – financially and structurally – as never before.

For us, it was the first year when we ended the year with a financial deficit. A position we definitely don't want to be in. Having identified the likelihood of this early in the financial year we are now working with colleagues at our regulator – Monitor – to look to find a way to get us back on track and work is already progressing well. Central to this is a new turnaround team set up specifically to re-shape our resources and ways of working at CHFT to ensure we are in the strongest position to face the future.

Locally, the first half of the year in particular, was dominated by discussion and debate around the outline proposals drawn up by ourselves, Locala and South West Yorkshire Partnership Foundation Trust on how the health system in Greater Huddersfield and Calderdale could work sustainably going forward. It included proposals for changing the way that health care is delivered both closer to home in the community and within the hospital setting, including emergency care provision. This was always going to be an emotive subject but there is no question from a patient safety and quality of care perspective, as well as financial, that change has to happen.

The decision on the proposals has always been one for our commissioners to take and, as a result of looking at all proposals before them, our local commissioning groups decided the focus for that change would initially be on boosting community healthcare before changing the way hospital care is provided. So it was excellent news in March when we – and our partners in Calderdale – were appointed one of the new “vanguard” healthcare providers by NHS England. It means we are recognised as one of the forerunners of delivering healthcare in new ways. This includes more care available in people's homes, in their GP's surgery, in local health centres and pharmacies.

Focussing on care in our hospitals we staged two “Perfect Week” campaigns. These were very intensive. We measured and assessed our patients' progression with us from diagnosis to discharge to try to eliminate delays and duplication to provide better, seamless care. We are, of course, aiming for every week to be a Perfect Week and these two exercises have provided us with a real overview of what works well and where the improvements could be made.

Another major development is our collaboration with colleagues at Bradford Teaching Hospitals Trust to sign a 10-year IT contract in March which puts both our Trusts at the forefront of IT-supported healthcare. Caring for around 1 million patients in West Yorkshire between us, our Trusts are now set to introduce Electronic Patient Record systems – reducing all the paperwork involved in patient care and enabling our wards and clinic teams to spend more time with patients. This will not be implemented until 2016 but work is already underway to prepare for the transformational change this development will bring.

I am also delighted that during this year, David Birkenhead joined the Board as the Executive Medical Director from his previous role as Divisional Director of Diagnostics and Therapeutic Services.

Finally, the outstanding achievement of the year was a great example of teamwork – the opening of our Acre Mills outpatients and healthcare centre. Created in the empty shell of a former wire mill across from Huddersfield Royal Infirmary, more than 100,000 outpatients' appointments will be held there every year from now on. The lasting result of creating such a modern facility in a historic, much-loved landmark in the community is a triumph of creativity and real evidence of our determination to provide the very best care locally and make best use of our resources.

So there is still much to do, but just as importantly, a lot has already been done at CHFT in this very challenging year. It is all change yet at the heart of it all remains our commitment to providing care with compassion. And that will always be the case at CHFT.

This mix of change and development will be a challenge for us all in this year and I thank our staff, our membership councillors and members, our patients and their families, for their continued support in all we do,

Thank-you

A handwritten signature in black ink, appearing to read 'Andrew Haigh'.

Andrew Haigh, Chairman

Overview

CHFT IN NUMBERS 2014/15



460,673

LOCAL CALDERDALE CCG & GREATER HUDDERSFIELD CCG POPULATIONS



142,307
A&E PATIENTS



123,323
IN-PATIENTS



438,332
OUT-PATIENTS



48,795
DAY CASES



287,995
TOTAL COMMUNITY CONTACTS



223,887



64,108



£343m
EXPENDITURE 2014/15

£185.22m
CLINICAL STAFF BUDGET



96,000
ACCOUNTS PAYABLE
TRANSACTIONS

22,000
ACCOUNTS RECEIVABLE
TRANSACTIONS



320,000
X-RAY'S PERFORMED



82
PROFESSIONS



1872
NURSES



535
DOCTORS



466
THERAPISTS



544
COMMUNITY STAFF



5713
TOTAL BIRTHS



102
HOME BIRTHS



2944
BOY BIRTHS



2769
GIRL BIRTHS



3000 HRI
3560 CRH
SWITCHBOARD CALLS



6480
HRI WEEKLY MEALS



MEAT PIE
FAVOURITE
HRI MEAL



31,527
HRI LITRES OF SOUP



1305
CRH DAILY MEALS



FISH FINGER
CRH FAVOURITE
CHILD MEAL



CHICKEN
CRH FAVOURITE
ADULT MEAL







Strategic report

Strategic report

The purpose of this report is to provide information to the readers of these accounts to help them assess how the Board of Directors have performed in promoting the success of the Trust.

This report is prepared in accordance with sections 414A, 414C and 414D of the Companies Act 2006 as interpreted in paragraphs 5.2.6 to 5.2.11 in the government financial reporting manual. For the purposes of this report the Trust has treated itself as a quoted company. More information about our plans for the next year and over 3 -5 years can be found on the Trust's website and the Monitor website. Information on any mandatory disclosures included in this report can be found as part of our Code of Governance section on p132.

Who we are

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

The principal location of business of the Trust is:
Trust Headquarters,
Huddersfield Royal Infirmary,
Acre Street,
Lindley,
Huddersfield,
West Yorkshire
HD3 3EA

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

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

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

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

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

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

As a Foundation Trust – a status gained in 2006 – we have had the freedoms to develop and invest in our services to make sure they are tailored to the best needs of our patients. This status has enabled us to develop Acre Mills in Lindley, Huddersfield with development partners Henry Boot which opened as our new outpatients centre in February 2015.

Our vision and values

The Trust has recently refined its vision and values to ensure that the work it carries out always 'puts the patient first' and the Trust is working hard to improve the patient experience.

The Trust's vision is:

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

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

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



What we do

In 2014/15 Calderdale and Huddersfield NHS Foundation Trust cared for more than 123,300 men, women and children as inpatients (stayed at least one night) or day cases and more than 438,300 people attended our outpatient clinics. Our A&E departments at both hospitals saw and treated more than 142,000 people. There were some 223,887 adult services and 64,108 children's service contacts by our community teams.

Our 6000 colleagues provide compassionate care from our two main hospitals, the Calderdale Royal Hospital, and the Huddersfield Royal Infirmary, as well as in our community sites, health centres and in patients' homes.

During 2014/15 our clinical services were divided into four divisions each headed up by a clinical Divisional Director, supported by an Assistant Director of Nursing, an Assistant Divisional Director and an Assistant Director of Finance.

Division of Medicine

The Division of Medicine provides a comprehensive range of services through its three clinical directorates of Acute Medicine, Integrated Medical Specialities & Intermediate and Community Care. It provides its services across the two main hospital sites as well as through various community bases across the Calderdale and Greater Huddersfield geography.

The Acute Medicine directorate provides outpatient and inpatient services across the subspecialties of gastroenterology, diabetes, complex care, cardiology, respiratory and stroke service. The Acute Medical Unit and short stay wards are provided through the Emergency Care Network with our Surgical Division.

Integrated Medical Specialities provides oncology, haematology, dermatology, rheumatology, neurology, nephrology and medical daycase services.

The Intermediate and Community Care directorate provides all district nursing, community matrons, end of life, and intermediate care, crisis intervention and support and independence services across Calderdale. In addition it provides all of community therapy services across both Calderdale and Greater Huddersfield.

Division of Diagnostic and Therapeutic Services

The Division of Diagnostic and Therapeutic Services provide a full range of clinical support services including radiology, pathology, pharmacy, and medical records and appointments.

In addition Huddersfield Pharmacy Specials is hosted as a separate business unit which operates a commercial pharmacy manufacturing unit that supplies the West Yorkshire region and continues to attract new business from across the UK.

The radiology directorate provides a full complement of services, including interventional radiology. CHFT is a joint centre with Bradford Teaching Hospitals in delivering

vascular services to the West of West Yorkshire population. Our service continues to provide MRI and non-obstetric ultrasound as part of the accredited Any Qualified Provider framework. The service is continuing to develop its outreach and community provision of services. The directorate also hosts medical illustration and medical devices services.

The pathology directorate is a fully accredited service that provides a full complement of services including, blood sciences, transfusion, histopathology, microbiology and phlebotomy.

The directorate hosts the newly established community based integrated anticoagulation service which is delivered in collaboration with our local GPs. This allows patients to access care closer to their homes from medication initiation to follow up appointment. The service is available across 8 accessible locations within the Greater Huddersfield area.

The pharmacy service includes a comprehensive clinical pharmacy service, inpatient dispensary and aseptic service on both hospital sites. Outpatient dispensing is now delivered through an outsource arrangement, with facilities including our new outpatient service at Acre Mill.

The medical records and appointments directorate supports the function of booking new and follow up appointment across outpatient services and ensuring clinical records are in the right place at the right time for our patients. The commitment to a paperless environment will be delivered by a full deployment of the Electronic Document Management systems that went live in the Trust in February 2015, perseverance in achieving full roll out across both sites will contribute significantly to the success of Electronic Patient Record (EPR) and a paperless hospital.

Division of Surgery and Anaesthetics

The division of Surgery and Anaesthetics provides a comprehensive range of service through its four clinical directorates of critical care and anaesthetics, emergency care, orthopaedics and trauma and general specialist surgical services.

The critical care and anaesthetic directorate provides inpatient and outpatient services, pre -assessment, pain services, intensive care and high dependency units, elective and acute theatre provision.

The directorate of emergency care currently provides Accident and Emergency care at both sites and a surgical assessment unit at Huddersfield Royal Infirmary.

The orthopaedic and trauma directorate provides outpatient and inpatient services across the specialties of elective surgery, orthopaedic and trauma.

The general specialist surgical services provides inpatient and outpatient services across the specialties of general surgery, breast surgery, colorectal surgery, upper gastrointestinal surgery, including bariatric surgery, vascular surgery, urology, maxillo-facial, ophthalmology, and ear, nose and throat surgery to the populations of Calderdale and Huddersfield.

The division also provides day case surgery in all specialties. Division of Children's, Women's and Families (CWF).

The Children's Women's and Families services provide a comprehensive range of services within the two hospital sites and also the community.

The women's directorate encompasses the services of maternity care, gynaecology, gynae-oncology, termination of pregnancy, sexual health and HIV services.

The families directorate is community based and provides community midwifery services and health visiting. The Directorate also has the community therapy service which provides a service across Calderdale and Huddersfield boundaries.

The children's directorate provides acute services including paediatric assessment and inpatient services as well as paediatric outpatients. The children's directorate is home to the neonatal intensive care unit providing for special care babies including high dependency unit (HDU) and intensive care unit (ICU) provision. The community home nursing team also support children and their families at home with their intensive care needs.

The four divisions are supported by a number of corporate functions such as finance, quality assurance, human resources, estates and health informatics. Each corporate function reports through to a dedicated director.

Changes for 2015/16

Early in 2015 plans were put in place to change the directorate structure to reflect the direction of travel to care closer to home and community based services. CWF and DATS have merged and a new Community division has been created with effect from 1 May 2015. In addition, responsibility for A&E has moved from surgery and anaesthetics to the medical directorate, recognising the importance of senior medical review on patient flow and A&E performance.

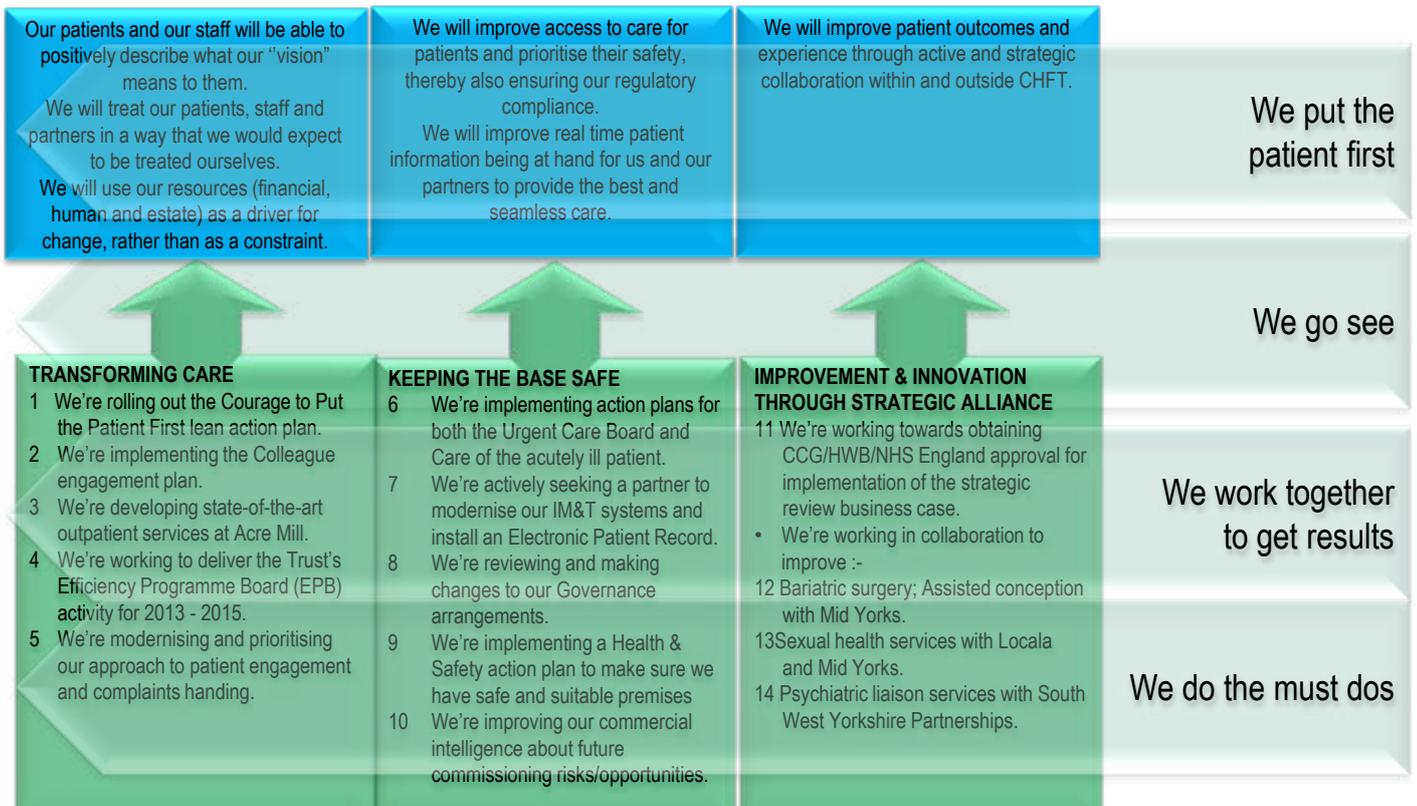


Our strategy

Our strategy for 2014/15 was based on three key areas of focus, supported by 14 responses – set out below. The delivery of these was closely monitored by the Board throughout the year.

CHFT

We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.



In June 2014 the Trust submitted its five year strategic plan to Monitor. The strategic plan recognised that the current models of community and hospital service provision in Calderdale and Greater Huddersfield are neither clinically or financially sustainable into the future. The plan summarised the detailed work the Trust had undertaken in early 2014 in partnership with South West Yorkshire Partnership NHS Foundation Trust and Locala to prepare an Outline Business Case. This formed the basis for the Trust's longer term five year strategic plan and provided options for whole system service transformation that could improve clinical and financial sustainability.

The options that were identified could enable the delivery of more services close to home or in the community and the consolidation of acute and emergency services on one hospital site with planned care provided on the other hospital site.

The proposals described in the Outline Business Case were based on a strong clinical evidence base (including the recommendations made by the National Clinical Advisory Team in June 2013) and the views expressed by local people through public engagement.

The Outline Business Case was submitted to Calderdale and Greater Huddersfield Clinical Commissioning Groups in June 2014 for consideration. In September 2014 the Clinical Commissioning Groups reported that any public consultation on changes in the configuration of hospital services would not commence in 2014 and would be delayed to a later stage after changes had been implemented to deliver integrated community services. This means that the Trust was not able to progress the service transformation options described in the Outline Business Case and the five year strategic plan.

During the first quarter of the year it became clear that the Trust was facing significant financial challenges and would not deliver the original financial plan. The Trust reported to Monitor a continuity of service risk rating (CoSRR) of 2 and an unplanned deficit of £4.3m to the financial year end 2014/15 against a planned CoSRR of 3 and a planned surplus of £3m. A re-forecast plan was submitted in September 2014, prompting an investigation by the regulator and the Trust was found in breach of its licence in January 2015. The Trust agreed to a number of enforcement undertakings. This included delivery of the reforecast plan, development of robust quality and financial plans for 2015/16 and the development of a strategic turnaround plan by September 2015. The Trust also put in place strengthened financial governance and programme management arrangements with external support. The Trust has also undertaken a well-led governance review self-assessment which will be independently tested and reported on in June 2015.

The strategic turnaround plan will be developed with Commissioners and NHS England and will include a detailed diagnosis of the drivers of the Trust's underlying deficit and strategic reconfiguration proposals for the Trust and

local health economy including a plan for consultation and implementation.

During 2014 Calderdale, Greater Huddersfield and North Kirklees CCGs confirmed their commissioning intentions in relation to Care Closer to Home. In Kirklees the two CCGs launched a competitive procurement of these services. The Trust developed a proposal for these services working in partnership with the three GP Federations in Kirklees, Forget Me Not Children's Hospice and Mid-Yorkshire Hospitals Trust. This creates a significant opportunity for the Trust to deliver integrated primary, community and secondary care services in Kirklees that enhances the options described in the strategic plan submitted in 2014. In Calderdale the CCG has confirmed that it is working collaboratively with the Trust, GP Federations, Social Care, SWYPFT and Locala to develop and implement a Multi-speciality Care model of service delivery.

All of this highlights that over the past year there have been significant changes in the strategic context in which the Trust is operating. These changes and our Monitor Enforcement Undertaking to develop a strategic turnaround plan means that the Trust (working with Commissioners and NHS England) will recreate our longer term strategy for clinical and financial sustainability by September 2015.

We believe that many of the proposals we identified in the strategic plan submitted last year (and the Outline Business Case) remain valid. The Trust's challenges related to clinical and financial sustainability are largely associated with the current duplication of services across two hospital sites. In the longer term the provision of services closer to home and the consolidation of acute and emergency care and planned care will be important to resolving this. The increased strategic opportunities we now have for integration of services with primary care and the development of new networks of care across West Yorkshire will be important enablers that will enhance the plans we developed last year.



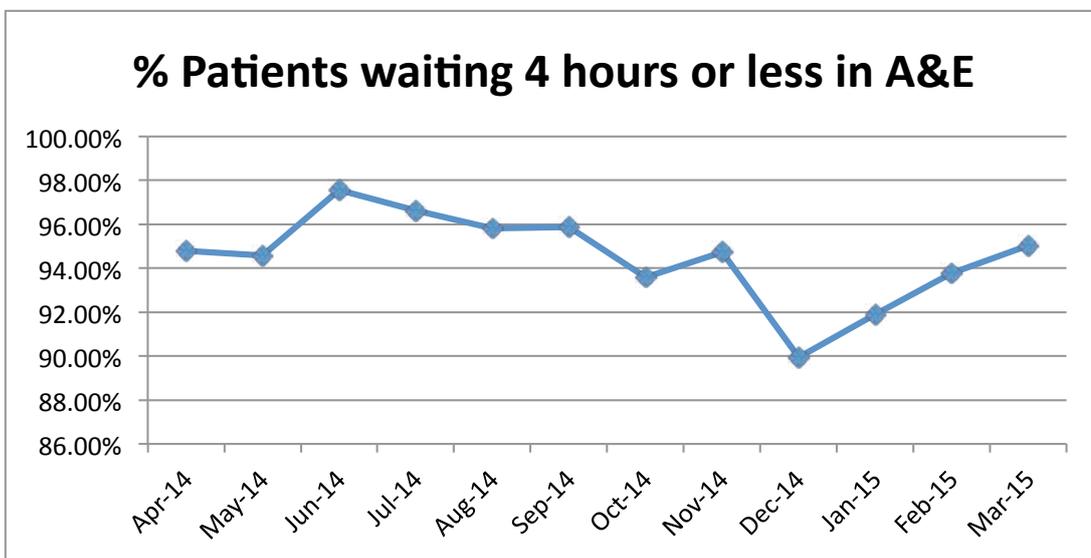
Our performance

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

The Trust’s performance against a range of national targets and standards is assessed and reported externally. 2014/15 was particularly challenging and we worked hard to continue to provide safe, compassionate care for all of our patients with a high level of patient satisfaction, while continuing to achieve the demanding efficiency savings and financial balance. We delivered a strong performance across all of our targets for the year, including 18 week referral to treatment, the cancer waiting targets and the re-forecast financial plan.

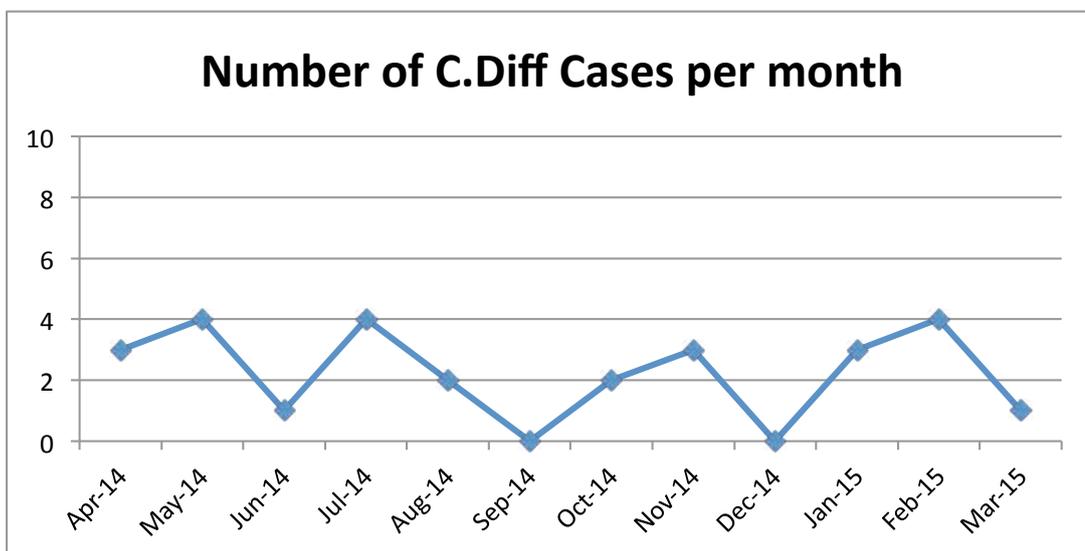
There were four areas where we have put in place additional action to address performance issues:

Emergency care



Like many other Trusts, we had some difficulties in delivering the 4 hour A&E target. This resulted in underperformance against this target in quarters 3 and 4 of 14/15. A project has been put in place to ensure this is back on track for 15/16. This has included advice from the National Emergency Care Team. Work is being done with external and internal partners, to put new systems in place to enable improvements to be made. In particular we have closer links with social care in both Calderdale and Kirklees to reduce the number of patients waiting for packages of care.

Hospital acquired infections – Clostridium Difficile (C Diff)





The Trust has low rates of infection. Because of this our commissioners set us a very low target for Cdiff cases of 18 or fewer. Unfortunately we had 27 reported cases of C Diff at the end of the year. Of these 10 were agreed as avoidable and 17 as unavoidable. All cases were investigated and valuable learning identified and shared for the majority of cases. The commonest issues were delay in obtaining and sending specimens for testing and delay in isolating patients with loose stools. For 15/16 we have a target of 21 cases. We are re-energising our infection prevention work and will continue to engage our staff, patients and visitors in maintaining good hand hygiene.

Diagnostic waiting list within 6 weeks

We struggled to deliver the 6 week access to diagnostics target during 14/15 with a year-end performance of 98.69% against a target of 99%. This was specifically due to access to MRI. Demand for MRI has also increased over the year. To address this we have purchased more MRI scans from the visiting mobile MRI service, and in 15/16 we will be looking to deploy a more permanent solution to this.

Cancer targets

We have successfully delivered the cancer targets, except for access to treatment within 62 days following a referral via a screening service. This only involves a small number of patients who come to the Trust for treatment following a visit to the breast cancer screening service or the colorectal screening service. The delays are predominantly due to patient choice in terms of appointment times. We will be working with the screening services, patients, and GPs, to ensure everyone understands the urgency of attending an appointment for a potential cancer treatment.

Improving quality

All of our patients, whether an outpatient, inpatient or in one of our emergency departments expects to receive only the best, the safest and most compassionate care.

Delivering the highest quality care for our patients is a priority for the Trust and is part of everyday working life for all our staff.

In 2014-15, we had much to be proud of in our quality achievements. Some of the highlights were:

- A reduction in the number of falls causing serious harm
- Improvements in complaints handling
- Supporting patients with long-term conditions to manage their condition through supported self-management courses
- Improving the care of patients with diabetes so that they do not develop complications and stay longer in hospital
- Improving the quality of food in partnership with other health and community providers

More information on how we have improved the quality of care can be found in our on p57.

The NHS Constitution

All NHS bodies are required by law to comply with the NHS Constitution, the national document which details the principles and values of the NHS in England. The Constitution sets out rights to which patients, the public and staff are entitled and pledges that the NHS is committed to achieve. It also describes the responsibilities that patients, staff and the public owe to one another to ensure the NHS operates fairly and effectively. Our Trust is fully compliant with the requirements of the NHS Constitution. During 2015/16, as part its Well Led Governance Review, the Board of Directors have committed to a full review against the NHS Constitution.

Future service challenges and plans

During 2014 the ten Clinical Commissioning Groups across West Yorkshire have been developing their plans for a review of services across West Yorkshire. This will include:-

- urgent and emergency care
- stroke services
- children's services
- cancer

The purpose of the review is to enhance clinical and financial sustainability across West Yorkshire health and social care. Whilst the programme is currently in the early stages, we will continue to work closely with the group to ensure that the outcomes are reflected in our longer term plans for the Trust.

The Trust's challenges related to clinical and financial sustainability are largely associated with the current duplication of services across two hospital sites. In the longer term the provision of services closer to home and the consolidation of acute and emergency care and planned care will be important to resolving this.

The implementation of 7 day working is challenging for the Trust. The NHS England standards include:-

- All admissions seen by a suitable consultant within 14 hours of admission, or within 6 hours between 0800-2000, except patients who are very ill, where it should be 1 hour;
- Hospital inpatients must have scheduled seven-day access to diagnostic services;
- Support services, both in the hospital and in primary, community and mental health settings, must be available seven days a week.

The NHS Five Year Forward View was published in October 2014. This introduced new strategic options for breaking down the barriers in how care is provided between family doctors and hospitals, between physical health and mental health, and between health and social care.

Building upon the extensive work already undertaken across Calderdale and Huddersfield and the 6 organisations delivering health and social care, the Trust has developed significant new partnerships and models of care with the four GP Federations across Calderdale and Kirklees. These models of care are consistent with the Multi-Speciality Care and Primary and Acute Care Systems described in the NHS Five Year Forward View.

The Trust is also a partner in the recently announced selection of Calderdale as a national vanguard site for multi-speciality care models. Our aim through this venture is to provide long-term sustainable health care solutions which are of high quality, safe and are financially robust.

Our intention is to deliver a new way of working that increases self-care, provides integrated care closer to home, and provides better access to services by enabling 7 day working.

Our principle aims are now embedded into our work and we will continue to:-

- Reduce mortality rates in hospital
- Improve patient experience and safety
- Provide better care for less cost
- Reduce the number of unnecessary emergency admissions
- Improve patient flow and reduce hospital unnecessary waits for care

Care closer to home has a significant reliance on technology which will be a key enabler in the delivery of safe joined up care. Over the last twelve months, in partnership with Bradford Teaching Hospitals Foundation Trust, we have undertaken to identify an Electronic Patient Record (EPR) supplier with the capacity and capability to partner the two Trusts in their journey to become 'World Class' providers of IM&T enabled clinical services. The procurement is now complete and a contract has been awarded to Cerner Corporation. The project was launched on April 1st 2015 and go-live is planned for summer 2016. The programme will not only remove the reliance on paper, but will fundamentally change the way we deliver services.

In these times of rapid system change we need to ensure that we do not lose sight of the basics. We must keep the operational, quality and financial base safe and sustainable. Through our plans we aim to continue to improve access to care for patients and prioritise their safety, and thereby ensure our regulatory compliance.

Our principal risks and uncertainties

A significant amount of work has been undertaken on the Trust's board assurance framework and risk management arrangements during 2014/15 and this programme of work will continue in 2015/16. The programme places an equal and proactive emphasis on quality, safety, performance and financial risk and has raised the profile of risk management within the Trust's overarching governance arrangements. A description of the principal risks and uncertainties facing the Trust is set out in the Annual Governance Statement on p137.

The board assurance framework is reviewed twice a year by the Audit and Risk Committee. It is regularly reviewed and then signed off each year by the Board. The Board also receives a report of the top risks facing the Trust each month.

The principle risks and uncertainties faced by the Trust are:

- Ability to deliver the financial plan and the associated efficiency savings
- Ability to continue to deliver the targets and outcomes set within the regulatory and compliance frameworks
- Lack of progress in service reconfiguration impacting on the Trust's ability to deliver safe services particularly in relation to providing an A&E on two sites
- Challenges in recruiting into specific specialties and grades (particularly A&E consultants and middle grade doctors) and the required number of nurses to achieve safe staffing
- Continued challenges in reducing HSMR and SHMI
- Delivery of the electronic patient record programme across the Trust

The relevant controls and mitigation for these risks are included in our corporate risk register.

How we are governed

The way in which foundation trusts are governed is set out in legislation, which is reflected in our Constitution and our Standing Orders. We have a Board of Directors and a Membership Council.

The Membership Council is elected by the membership of the Trust within each constituency. The Membership Councillors represent the members' interests and those of the wider public and staff and reflect these interests to the Board of Directors. The Membership Councillors also feedback information on the Trust, its vision and plans, to the public, staff and stakeholder organisations who have elected or appointed them.

The Board of Directors has the overall responsibility for setting the priorities of the Trust and decision making. They work closely with the Membership Council in formulating forward plans. More information on the responsibilities of the Board of Directors and the Membership Council and how they work together is provided in the Governance section on p50. The Board of Directors has developed a schedule of matters reserved to the Board and a scheme of delegation to its sub-committees and executives. This is available on the Trust website at www.cht.nhs.uk.



Our people

At the end of 2014/15 we employed **5,947** people:

This number is broken down as follows:

Staff group	Number
Additional professional scientific and technical	178
Additional clinical services	1352
Administrative and clerical	1187
Allied health professionals	473
Estates and ancillary	159
Health care scientists	129
Medical and dental	540
Nursing and midwifery registered	1928
Students	1
TOTAL	5947

Comparison of our workforce over the past three years by age and gender:

Age	2012/13		2013/14		2014/15	
	Number	%age	Number	%age	Number	%age
0-16	1	0.02%	0	0	0	0
17-21	73	1.23%	96	2%	87	1%
22+	5859	98.75%	5958	98%	5860	99%
Gender	Number	%age	Number	%age	Number	%age
Male	1082	18%	1074	8%	1055	18%
Female	4851	82%	4980	82%	4892	82%

Board of Directors



Senior Executives



Health and safety

A health and safety framework is embedded within the Trust. An annual health and safety report provides assurance to the Trust Board of progress being made against the work plan and identifies improvement areas for the following year. Performance against the work plan is monitored by the Trust's Health and Safety Committee.

The Trust began a dedicated health and safety training programme during 2013 which will continue throughout 2015/16. The training provides staff with the tools and techniques to proactively manage health and safety.

The Trust has over 800 trained fire wardens in place ensuring fire safety is a key component to providing a safe and well managed healthcare environment. The Trust continues to work in partnership with local fire brigades enabling familiarisation exercises to take place on both main hospital sites.

Sustainability

In 2014/15 the Trust has continued to implement measures to reduce its environmental impact.

In terms of improving energy efficiency, Acre Mill Outpatients opened in February 2015 with a BREEAM Very Good rating for its design and operational efficiency. At Calderdale Royal Hospital, the external lighting has been upgraded, and controls have been installed for the internal lighting to ensure they only operate when required. Ward refurbishments have continued at Huddersfield Royal Infirmary incorporating the most modern light fittings and equipment, and the laundry services have been transferred to an external provider reducing demand for energy on site.

Other areas such as waste and transport have seen a review of existing activity, and efficiencies have been realised through contract management processes.

2015/16 will see the launch of the Trust's Sustainable Development Management Plan and associated action plan to reduce carbon emissions in line with national targets. The plan will outline the Trust's social, economic and environmental commitments to ensure the realisation of one of its core values to 'create and sustain health and wealth for the future.'

Social and community issues

The Trust works with a number of local schools and colleges offering work experience and placement opportunities. The Chief Executive and other senior management also participate in the Take Over Day scheme. The Trust continues to support our apprenticeship scheme. As at 31 March 2015 the Trust employed 31 apprentices, which is comparable with the number employed at the same time the previous year, and the Trust is working towards a year on year increase in staff under the age of 25. The Trust has also formed links with key community and voluntary sector

organisations including Kirklees Blind and Low Vision Group and Calderdale Equality Forum.

We were delighted to welcome sixth form volunteer students on to wards to work with our elderly patients and support our staff delivering dementia care. The students, many of who are hoping to pursue careers in medicine, supported staff with a range of activities to stimulate our patients' memories. These included looking at photographs of their families and where they used to live and gentle activities such as jigsaws. One of the students on this scheme was Student Volunteer of the Year at the annual staff awards.

We have a number of policies in place which cover social, community and human rights matters. These policies are subject to an equality impact assessment which considers the impact of the policy on a number of protected characteristics as well as wider human rights issues. We continue to provide positive support to people with a disability who wish to secure employment with the Trust through the Guaranteed Interview scheme and comply with two tick's requirements. There are policies in place which support staff who may become disabled during their employment.



Our finances

At the end of March 2014 the Trust had developed an operational and financial plan for 2014/15 to deliver a £3.0m surplus and maintain a Continuity of Service Risk Rating (CoSRR) at level 3.

These plans were predicated on the complete retraction of the additional capacity that was put in place to manage winter pressures within the final quarter of 2013/14. However, due to continued operational pressures and the requirements from its main Commissioners to provide system-wide resilience over the Easter period, additional, unplanned capacity was in place throughout the entirety of quarter one of 2014/15.

This operational picture had a negative impact upon the delivery of the Trust's ambitious cost improvement programme (CIP) of £19.5m and placed greater risk against the delivery of the programme within the remainder of the year. At the same time, and following a significant review of the nursing workforce under the 'Hard Truths' initiative, the Trust also committed to invest an additional, unplanned £1.5m within this area.

As a direct result of the above, the Trust experienced significant financial pressures within the early part of 2014/15 that resulted in an unplanned financial deficit position and an unplanned CoSRR at level 2. The Trust reported this position to Monitor and also recognised that it was not able to deliver the planned surplus for the year or the planned CoSRR of level 3.

Consequently, the Trust reforecast the year-end financial position and submitted to Monitor in September 2014 a formal reforecast plan for 2014/15. This reforecast plan described a year-end deficit position of £4.3m and a year-end CoSRR at level 2.

Given the size and scale of the movement between the original and reforecast plan, the Trust engaged with external management consultancy to validate the reforecast plan and to review the Trust's financial modelling of the impacts this would have upon the following year of 2015/16.

In January 2015, the Trust entered a voluntary turnaround process and resourced a permanent Project Management Office (PMO). The PMO consists of Trust colleagues supported by external management consultancy resource to give guidance to the development of robust efficiency programmes and to give additional short term management capacity.

At the same time, following a review of the Trust's financial position and the reforecast position, Monitor declared the Trust to be in breach of licence and laid out three conditions for the Trust to meet. These being:

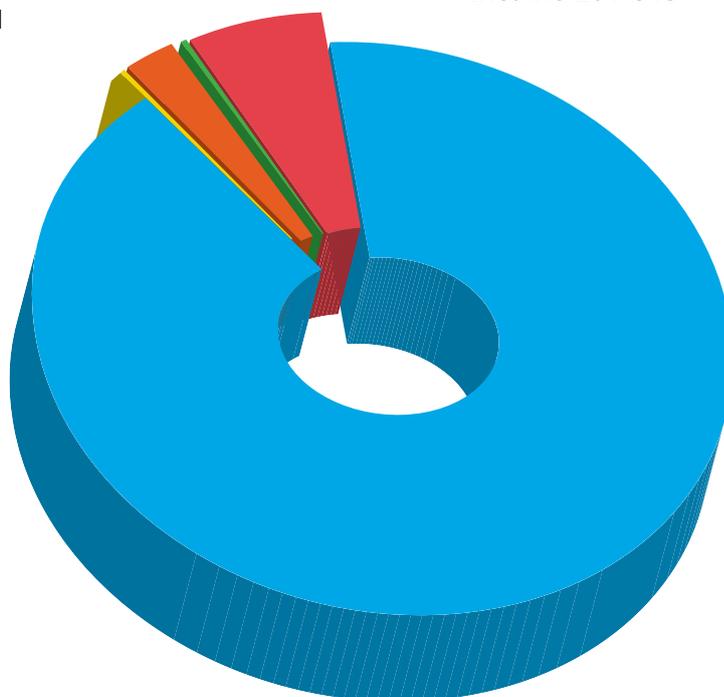
1. Delivery of the reforecast plan submitted in September 2014;
2. Plan for 2015/16 and ensure the efficiency challenge is met and consistent with the national efficiency requirements detailed within the 'The Forward View into Action: Planning for 2015/16';
3. Develop a strategic sustainability and financial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

Additionally the Trust was asked to complete a Well-Led Governance Review and sought independent support for this.

The Trust has achieved point 1 and delivered a 2014/15 financial position that is consistent with the September 2014 reforecast plan, with the key elements detailed below.

The Trust received a total income (excluding the positive impact of fixed asset revaluations) of £354m of which £321m came from patient care and £33m came from research, education, car parking and non-clinical services to other organisations.

Income 2014/15

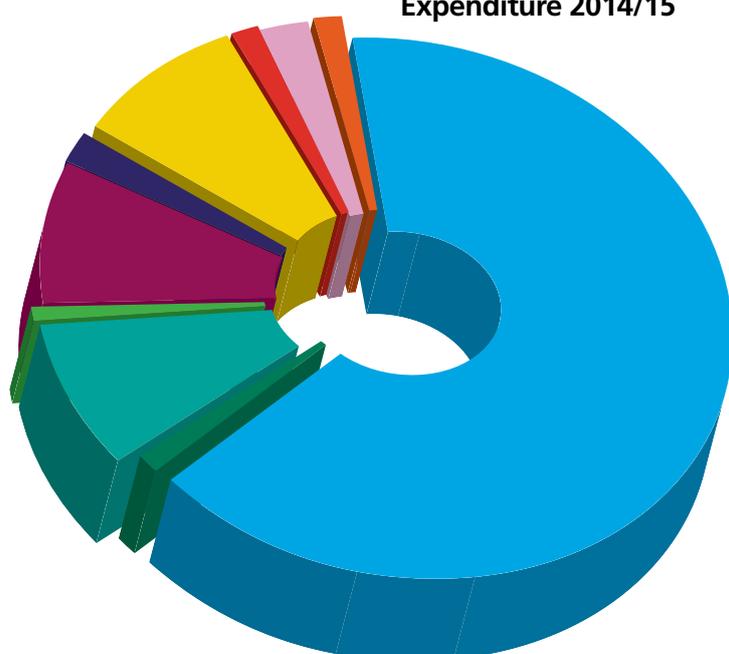


- Clinical Income £321m
- Research and Development £1m
- Education and Training £9m
- Charitable Donations £1m
- Commercial and Other £22m

Our principal purpose is the provision of goods and services for the purpose of the health service in England. We do not fulfil this purpose unless, in each financial year, our total income from the provision of goods and services for the purposes of healthcare is greater than our total income from the provision of goods and services for any other purpose. During 2014/15 we achieved this requirement. The provision of other goods and services has not had an impact on our ability to provide services for our primary purpose. Information on any post balance sheet events is provided in the notes to the accounts.

Operating expenditure (excluding the negative impact of fixed asset impairments and exceptional restructuring costs) was £342m. Our productivity and efficiency programme generated £9.9m of savings through a number of initiatives that were driven through the Trust's clinical divisions and corporate strategic planning.

Expenditure 2014/15



■ Staff £222m	■ CNST Premium £7m
■ Training and Consultancy £4m	■ Premises £30m
■ Clinical Supplies £29m	■ Equipment Leases £5m
■ General Supplies £3m	■ Depreciation £9m
■ Drugs £29m	■ Other £4m

Within the year the Trust incurred exceptional restructure costs of £4.4m to support and enable structural changes within the workforce. The costs related to a Mutually Agreed Resignation Scheme (MARS) and a Voluntary Redundancy Scheme (VRS) carried out throughout 2014/15. These costs had an immediate impact within the cash balance of the Trust but will deliver a recurrent cost saving within future years.

The Trust recognises the importance of continued capital

investment and although a reduction in capital spend occurred when compared to the original plan the Trust invested £22.5m in the following areas:

- Medical equipment investment £2.9m
- Theatre refurbishment at HRI £2.5m
- Information technology - infrastructure investment of £4.0m
- Information technology - clinical systems investment of £5.3m
- Operational and infrastructure schemes £7.8m

Within the year the Trust concluded its procurement of an Electronic Patient Record (EPR).

This investment will be supported through external borrowing from the Independent Trust Financing Facility (ITFF) and will continue at pace until the planned go-live of August 2016.

Financial risk rating

The Continuity of Service Risk Rating (CoSRR) is used to flag the risk of insolvency over the short to medium term (12-18 months), using a scale of one to four; with the lowest rating signifying the highest level of concern.

As described above our CoSRR over the last year was at level 2.

Financial risks and future plans

The Trust continues to operate in a challenging financial environment being shaped by the national financial picture with the on-going need to reduce the public deficit. This sits alongside the continued pressures of investing in clinical staffing ratios, providing services 7 days a week and responding to increasing demand.

As described above the Trust has used its 2014/15 financial performance to model the plan for 2015/16 alongside the activity forecasts and capacity requirements for its services and is planning for the following income and expenditure position:

- Underlying financial deficit of £34m;
- CIP delivery in line with national requirements of £14m;
- Planned deficit position of £20m.

Although the Trust closed 2014/15 with a cash balance of £14m, the Trust cannot sustain the above financial performance without the requirements of external cash support. As such, the Trust has been in communication with Monitor and the ITFF to arrange for working capital facilities to enable the Trust to operate throughout 2015/16 and is planning for a working capital loan of £15m.

The Trust is also planning to continue to invest in transformational capital IM&T and estate schemes in 2015/16. The total capital expenditure being planned is £21m of which £10m is being funded by way of a pre-approved capital expenditure loan from the ITFF to support the investment within the EPR system.

The longer term stability and financial sustainability plans will continue to be developed in line with Monitor's third condition for completion in September 2015.

Accounts preparation

Our accounts, which begin on p151 of this document, have been prepared under a direction issued by Monitor under the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

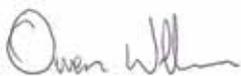
The Trust has closed the year with a cash balance of £14m and positive net assets of £127m.

However, given the shape of the financial plans for 2015/16 there is a requirement for the Board of Directors to consider the impact these plans have on the organisation and hence must be able to demonstrate that the Trust is a going concern.

The following has been taken into account when the Board of Directors considered going concern:

- The Trust closed the year with £14m of cash but cannot sustain the planned deficit position within 2015/16 without the requirements of external cash support. As such, the Trust has been in communication with Monitor and the ITFF to arrange for working capital facilities to enable the Trust to operate throughout 2015/16 and is planning for a working capital loan of £15m. With this loan in place, the Trust will be able to meet its liabilities.
- The Commissioners continue to commission services from the Trust and although the Trust and Commissioners are yet to sign their main contracts for clinical services the Commissioners have continued with monthly transfers of fixed levels of cash based on contracted values for 2014/15. This incoming cash has enabled the Trust to meet all its obligations and liabilities within the first few months of 2015/16 and expect this funding to continue until contracts are signed with the associated revised cash flows.
- The PMO methodology has ensured that the CIP plans for 2015/16 are robust and deliverable. This programme methodology is built around a gateway approach for project design, development and delivery that includes a rigorous quality and equality impact assessment review. The schemes within the planned CIP of £14m have all progressed through gateway 2 and these represent detailed plans that are ready for implementation with key milestones being tracked and monitored on a weekly basis through an Executive Director led Turnaround Executive meeting. In addition, the Trust has developed a further £3m of schemes that have progressed through gateway 2 at the end of April 2015 and the Trust is confident that within the total gateway 2 values of £17m, a minimum of £14m CIP will be delivered in line with the planned levels.

In conclusion the Board of Directors has a reasonable expectation that Calderdale and Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.



Owen Williams
Chief Executive
28 May 2015









Directors' Report

Directors' report

The directors' report provides a review of the main activities of Calderdale and Huddersfield NHS Foundation Trust over the year.

This directors' report is prepared in accordance with:

- sections 415, 416 and 418 Companies Act 2006 (section 415(4)-(5) and sections 418(5)-(6) do not apply to NHS foundation trusts)
- Regulation 10 and Schedule 7 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008
- additional disclosures required by the Treasury's Financial Reporting Manual
- additional disclosures required by Monitor in its Annual Reporting Manual 2013-14.

Additional information on quality is available in our Quality Account on p57 and more information on quality governance is provided within our Annual Governance Statement on p137.

Achievements in 2014/15

The delivery of our vision is within the context of the strategic environment in which we operate. This is shaped by the national financial picture with the ongoing need to reduce the public deficit and increasing challenge to maintain the NHS funding ring fence. A bigger challenge will come for the Trust in 2015/16 as resources are realigned across Health and Social Care into the Better Care Fund. These factors sit alongside the need to invest in clinical staffing ratios, provide services 7 days a week and respond to increasing demand.

A detailed analysis of how we performed is included in the strategic report on p18, the Quality Account 2014/54 and in the regulatory report p34.

The Trust embarked upon a number of key service developments in 2014/15 to enhance the patient experience and provide both qualitative and system-wide efficiency, by ensuring that our patients are receiving the right service, in the right place at the right time.

The Trust built on existing service provision with a number of highlights:

- In March 2015 it was announced that the Calderdale Health and Social Care economy had been chosen as one of 29 national 'vanguard' sites. During 2015, the Trust will be working in partnership with partners including the Clinical Commissioning Group, Local Authority, Locala and GP Federations, the South West Yorkshire Partnership NHS Foundation Trust and voluntary organisations to develop local services under this programme of work.



- New Nerve Centre technology was piloted on two wards across both hospitals and will be fully implemented during 2015. This system uses small mobile devices at the bedside and wireless technology to send observation information to a central system where it can be accessed by other health professionals. The system will send automatic reminders when observations are due and also alerts when a patient's condition starts to change so early intervention is possible.
- New technology was also introduced for all community based clinical staff providing mobile kit to help them to deliver their services whilst on the go. The equipment consists of a light, durable laptop with a long life battery and a smart phone, both of which, when connected, will allow staff to access the Trust network whilst they are in a community setting. Updating and accessing patient records can be done both on line and offline which means records can be updated in the patient's home, instead of having to go back to base.
- Following feedback from patients a 'Hospital at Night' scheme was launched, *right*, aiming to reduce the levels of noise at night and allow patients to get a better night's sleep. The scheme is one of five projects that were identified as a priority for improvement from a patient experience event. An important element of the project is to make staff, patients and visitors aware of simple changes which can be made, such as toning voices down on the wards and being extra vigilant when closing doors and using bins. A good practice night-time routine checklist has been introduced to help the ward team identify environmental factors which may cause noise especially at night.
- Quest for Quality is an exciting model of care improving the level of support provided to Calderdale care homes and their residents to improve health outcomes. The Quest team completed its first year during 14/15 having a significant impact on outcomes for the local population. The team have helped to reduce admissions by more than 20% and bed days in hospital by 15%. Residents are also 50% less likely to need a visit from their GP.
- We have been working closely with our partners in both the GP Federations and the Mid Yorkshire NHS Hospitals Trust, to redesign how our sexual health services look across Calderdale and Kirklees. This work is in response to the local authorities procurement of the services, and has brought clinicians together to fully integrate genito-urinary medicine and contraceptive services to provide a one stop service both centrally in a hub and more locally in the community.
- The Trust continued to work in partnership with Overgate Hospice and Marie Curie to provide an enhanced Integrated End of Life service to the residents of Calderdale. The service offers additional out of hours support to patients approaching their end of life and supports the promotion and education of end of life issues with local health and social care professionals. During its first year the service has provided almost 1,500 specialist interventions to those approaching end of life. Patients and their families have told us this service is making a real difference to supporting them to continue to live in their own home.



New technology being trialled



Quest for Quality



- Two new innovations, *left*, were introduced for treating people with coronary heart disease. The first local procedure involves using dedicated equipment called a CrossBoss and Stingray to pass stents down the side of resistant blockages. This is a minimally invasive procedure can take up to four hours and is performed through a small tube in the wrist or groin. In addition an advanced technique using a tiny diamond coated drill, called a coronary rotator, was introduced. The drill bores through very hardened arteries. An expected 30 patients a year are due to undergo this innovative new procedure. In both cases the patient is usually fit to leave after an overnight stay in hospital, compared to a week's stay after open heart surgery.

- A new Maternity Assessment Centre opened at Calderdale Royal Hospital in March 2015. The Centre provides a 24/7 service for emergency maternity cases. The Trust has a record of providing excellent care for low-risk mothers in its birth centres and the new unit will provide the same excellence of care for higher risk mums by midwives on the unit.

- A new role of Clinical Commander has been introduced across both hospitals to help improve patient flow through the hospital and improve waiting times in A&E. The Clinical Commanders will work alongside matrons and medical staff to support the wards in timely and safe discharges for our patients.

- In partnership with general practice colleagues in Greater Huddersfield, the Trust has launched a new and innovative community anticoagulation service model. The new service will mean more people than ever are able to access services closer to their home.

- During the year the Trust introduced the Individualised Care of the Dying Document (ICODD). The ICODD was developed by representatives from specialist palliative care, chaplaincy, community nurses, ward doctors and nurses and the local hospices. The document incorporates clinical guidance and an individualised care plan. There are sections on good communication and on hydration and nutrition. It allows for the assessment of patients' spiritual and information needs and those of their families. Funding has been secured to enable us to provide "Comfort Bags" for families with items such as tissues, bed-socks, toothbrush and toothpaste, to help them during the days they spend at a loved one's bedside.



Aveta group

- A new specialist maternity well-being group was launched in Todmorden and Hebden Bridge to help women who have difficulties after the birth of their babies. Women who are struggling to cope are referred to the team which provides them with expert advice and support once a week for six weeks. Referrals come from other Health Visitors, GPs and the Family Support service.



End of life care

- The Trust also launched the Aveta Home Birth team, a new 24-hour team of dedicated home birth midwives. The service provides bespoke support for mums-to-be who want to have their babies at home and aims to provide personal one-to-one care for women throughout their pregnancy, labour and immediately following the birth of their baby.

- The Virtual Ward team continues to build on its success since its launch in December 2011. The Virtual Ward is a dedicated multi-disciplinary team designed to identify and support those patients who are at high risk of readmission following a discharge from hospital. Since its launch the team has contributed to the local priority of preventing avoidable readmissions to secondary care by contacting patients within 48 hours of a discharge, with the aim of reducing the number of patients returning to hospital within seven and 30 days post-discharge following an acute spell. The service also plays an important role in decreasing the burden on primary care, improving the communication between the hospital and existing community service and where necessary supporting those patients who require further hospital treatment to receive this treatment in a planned manner (i.e. avoiding admissions to hospital through A&E).
- During 2014/15 the Trust attracted national interest in our Outpatient Parenteral Antimicrobial Therapy service. The service provides intravenous antibiotics in a community setting as an alternative to inpatient care for those patients who are medically stable and able to receive care out of hospital. The number of patients benefitting from this service continues to grow and is a highly clinically efficient, cost effective and safe alternative to inpatient care.
- The Trust opened its new medical simulation suite in 2014. The state of the art facility, based at Huddersfield Royal Infirmary offers medical students, junior doctors, doctors, nurses, midwives and other healthcare professionals the chance to 'try out' their skills on adult and infant interactive manikins.
- An innovative model introduced within accident and emergency departments at the Trust means that a large number of patients who would have previously been admitted to hospital were safely supported to return home. This model involves a senior physician working closely with an experienced nurse and community matron to assess where it is safe and appropriate for a patient to be discharged home. Those who need a more thorough assessment do not then wait so long for their investigations and eventual diagnosis, and their decision to admit or discharge home is delivered more quickly. This service has significantly reduced the number of admissions to hospital and the waiting times within the department
- The Trust continues to work in partnership with South West Yorkshire Partnership NHS Foundation Trust to deliver a Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service that improves outcomes for patients and makes more efficient use of acute beds. The service provides a 24 hour, seven day a week mental health liaison service for those being treated for physical health problems within the hospital. The model of service is based upon the evaluation and findings of the RAID service provided at City Hospital in Birmingham, and aims to reduce admissions, length of stay, psychological distress, and increase the number of people who can be discharged to their own homes with appropriate assessment and support.



Maternity Assessment Centre



Simulation Suite



Our innovative A&E team

Regulatory report

Monitor is the sector regulator for healthcare, and regulates NHS foundation trusts based on the risks they face and how well the risks are managed. Each foundation trust board is required to submit a quarterly report to Monitor and performance is monitored against these reports to identify where potential and actual problems may arise.

Financial risk rating

In 2013/14, Monitor introduced a new compliance framework for foundation trusts. The new risk assessment framework replaced the financial risk rating with the continuity of services risk rating. This did not represent a significant change in the way in which foundation trusts are assessed.

Governance risk rating

Under the previous compliance framework, a 'green' governance risk rating indicated that an NHS foundation trust's governance arrangements complied with their provider licence and that there were no material concerns; an 'amber-green' rating indicated that there were limited concerns surrounding the licence conditions; an 'amber-red' rating indicated there was a breach of the licence conditions; and a 'red' rating indicated that there was a likely or actual significant breach of licence conditions.

Under the risk assessment framework, a "green" risk rating means that there are no evident concerns, and a "red" rating means that Monitor is taking enforcement action. Where Monitor has identified a concern within a foundation trust but not yet taken action, a narrative description is provided which states the issue at hand and the action it is considering.

Our projected risk ratings and actual performance for 2014/15 is shown in the table below:

2014/15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating	3	2	2	3*	2
Governance rating	Green	Green	Narrative	Narrative	Red

*The rating was adjusted to take account of the loan draw down, however the underlying CoSRR remained a 2.

Our performance for 2013/14 is provided below for comparison:

2013/14	Annual Plan	Q1	Q2	Q3	Q4
<i>Under the Compliance Framework</i>					
Financial risk rating	3	3	3		
Governance risk rating	Amber/Red	Amber/Red	Green		
<i>Under the Risk Assessment Framework</i>					
Continuity of service rating				2*	3
Governance Rating				Green	Green

In the first quarter of the year it became clear that the Trust was facing significant financial challenges and would not deliver the original financial plan. The Trust was found in breach of its licence and agreed to a number of enforcement undertakings including delivery of the reforecast plan by the year-end – this is explained in more detail on p24.

Further disclosures in relation to income and the Going Concern statement can be found in the Strategic Report on p26.

Our Estate

Following a substantial estates maintenance programme at the 50 year old Huddersfield Royal Infirmary (HRI), the building has seen significant progress within its infrastructure. However, further expenditure is required to ensure year on year improvements.

Capital works saw improved fire precautions with a replacement fire detection system and enhanced fire compartmentation. The Trust also commenced with a major refurbishment of Ward 7, replaced old switchgear, installed new medical air plan and commenced a replacement programme of its operating theatres.

The Estates Team, on behalf of the Trust, have a duty of care to ensure that appropriate governance arrangements are in place and are managed effectively in terms of complying with healthcare specific engineering standards. The Health Technical Memorandum series provides best practice engineering standards and policy to enable the Estates Team to manage and deliver this duty of care.

The Team have worked positively with external engineers towards compliance with the statutory healthcare engineering requirements and have provided assurance against these robust standards to the Board.

During the last quarter of 2014/15 the Trust started a phased occupation of the redeveloped Acre Mill site. The redevelopment of this old mill complex is to provide new state of the art outpatient facilities has been undertaken via the Pennine Property Partnership LLP (Joint Venture with the Trust and Henry Boot Developments Ltd).

The layout of the new facility is specifically designed to make efficient use of space through sharing of clinic rooms wherever possible; minimising distance of necessary travel between frequently used spaces; locating support services so that they may be shared by adjacent functional areas; and grouping functional areas with similar system requirements.

As well as the physical design, the move of outpatients to Acre Mill will enable changes in the way that services are delivered. Capacity and efficiency will be most significantly improved through the adoption of a three session working day in outpatients. The accommodation requirements for Acre Mill have been modelled on the basis of a 15 session week. This moves the organisation forward in delivering a 7 day working service.

The Acre Mill Outpatient Centre has been nominated for a Green Apple Environment Award which is an international campaign to recognise, reward and promote environmental best practice around the world. The building has also been nominated for a Heritage Building Conservation Award.

Calderdale Royal Hospital extended their Maternity Assessment Unit providing larger and up to date facilities enabling ante-natal services to be delivered 24 hours per day over a 7 day period.

Information Technology

Over the last twelve months, in partnership with Bradford Teaching Hospitals Foundation Trust, we have undertaken to identify an Electronic Patient Record (EPR) supplier with the capacity and capability to partner the two Trusts in their journey to become 'World Class' providers of IM&T enabled clinical services. The procurement is now complete and a contract has been awarded to Cerner Corporation with a planned go-live in summer 2016.

The programme will not only remove the reliance on paper, but will fundamentally change the way we deliver our services. During the transition or initiation period of the EPR, CHFT will focus on several tactical deployments that will deliver operational benefits and free up time to spend caring for patients as well as compliment the suite of services that will become available through EPR. These departmental services include e-observations, theatres and maternity systems. The commitment to a paperless environment will be delivered by a full deployment of the Electronic Document Management systems that went live in the Trust in February 2015. Perseverance in achieving full roll out across both sites will contribute significantly to the success of EPR and a paperless hospital.

Care Closer to Home has a significant reliance on technology which will be a key enabler in the delivery of safe joined up care. The community project will continue through-out 2015/16 giving community healthcare professionals remote access on or off line. We have also procured a Health Integration Engine which will allow the EPR to connect to any other system following some technical configuration and sharing agreements with all stakeholders this will promote a more cohesive approach across the local health communities.



Emergency Planning

As a category 1 responder, defined by the Civil Contingencies Act 2004, the Trust has civil protection duties placed upon it. We are also required to meet the requirements of the Emergency Preparedness, Resilience and Response core standards set by NHS England and submit a statement of compliance which was done in January.

To fulfil our obligations we must ensure that we have appropriate emergency plans in place. The Trust Major Incident Plan has been reviewed and approved and other plans supporting this are in place

We have been working closely with our colleagues at Yorkshire Ambulance Service to embed a renewed Business Continuity Management System helping to ensure that we have robust Business Continuity Plans in place to enable us to maintain critical services in the event of an emergency or disruption.

Emergency Planning in 2014/2015 has enabled the Trust to respond to the industrial action that has taken place, produce plans and make preparations in response to the Ebola outbreak in western Africa and ensured appropriate plans were in place to ensure the continuity of care when the Tour De France took place in July.

Planning is also underway for the upcoming Tour De Yorkshire, which will be coming through the Calderdale and Huddersfield areas, following the success of last year's Tour De France.

We continue to work with partner organisations both from within the NHS such as other NHS trusts, Clinical Commissioning Groups and NHS England and those such as the emergency services and local authorities to enhance co-ordination and efficiency.

Patient Experience

Understanding our patients' experience of their care and how we can make improvements is really important to us. We have several ways for gathering views and feedback on our services to help us improve for the future. These include:

- Through our Patient Advice and Liaison Service (PALS)
- By reviewing the complaints, comments and compliments we receive
- Through the results of our 'family and friends' test and the national patient surveys
- By reviewing and responding to patient feedback received from our website, NHS Choices, Twitter, engagement and consultation events and focus groups.
- Through our Membership Councillors, members and volunteers.

During 2014/15 our PALS team dealt with 1561 contacts. Key themes were appointments; communication and clinical treatment.

We have set up the Patient Experience & Caring Group to lead, support and report on activities related to patient experience, involvement & engagement. The Group is

a sub group of the Quality Committee. Membership includes representation from across the clinical divisions and involvement from key corporate functions.

In September 2014 the Group held a workshop, involving members, partners and the public, to look at what our patients have been telling us and to agree some priority areas for improvement. The result was 5 key projects in response to 5 key concerns raised:

- Ward Orientation – (to reduce patient anxiety) to improve orientation of patients to the ward supported by a range of information sources including: patient information boards at each bedside, a personal 'what is important for me' statement and provision of a public facing information board for patients / visitors about the ward.
- Regular Information Round (keeping patients informed) – The areas of particular concern relate to communication between doctors and patients about a patient's clinical condition, treatment plan, and expected outcomes. Clinical leads are taking this forward with ward based teams re how best to implement the changes.
- 'Hello My name is...' (treating patients as an individual) - This is a campaign founded by Dr Kate Granger who, as a terminally ill patient in hospital, felt it was important for staff to always introduce themselves before delivering care. Staff can pledge to always introduce themselves by name, have their name badge visible at all times and make sure that patients understand their role in their care or treatment.
- Reducing Noise at Night – (making patients visit/stay as pleasant as possible). Simple changes are being introduced, including asking staff to tone down their voices on the wards and being extra vigilant when closing doors and using bins. A good practice night time routine checklist is being shared with wards and a member of the project team is carrying out a walk-round to help the ward team identify environmental factors that may cause noise at night.
- How Can I Help You? (Being efficient) - Patients expressed a view that staff are not always empowered or enabled to respond to solve problems for them. There is a commitment to: being responsive to patients' needs, working with patients and Trust colleagues to resolve problems or issues and being empowered and taking responsibility for solving the problems identified.

Complaints

In line with the NHS regulations for complaints management published in 2009, we agree with all complainants how their complaint will be investigated and when they can expect to receive a written response. We have been introducing improvements to this process as we strive to ensure:

- Everyone feels confident to speak up if they are worried about any aspect of their care
- It is simple and straightforward to raise concerns and complaints
- We listen and understand the issues raised and make sure we agree how we will address these
- We respond in the way we agreed and the timescale we agreed
- We show the changes that are made as a result of the issues raised.

We have changed our internal processes to provide close monitoring of the investigations being carried out and introduced improved key performance indicators. Performance against these are reported monthly to the Patient Experience and Caring Group and through a monthly performance report to the Board. A quarterly quality report provides detailed analysis of the issues being raised through complaints and concerns.

During 2014/15 we received 617 complaints and 359 were upheld or partially upheld. 219 related to in-patient care; 170 to out-patient care and 155 to emergency care. The main themes from complaints during the year were: clinical treatment; communication and appointments. Since April 2009, complainants have had the right to request an independent review of their complaint by the Health Service Ombudsman. During 2014/15 22 were referred to the Ombudsman. Of those 10 were not investigated, were not upheld or required no further action.

Colleague engagement

We know that effective communication and staff engagement is essential in designing and delivering high quality services to meet current and future challenges that meet the diverse needs of the people who use our services. We believe that colleagues are more likely to be motivated

and experience higher levels of job satisfaction when the following factors exist in the workplace:

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

The Trust launched a colleague engagement strategy in June 2013. The strategy adopts a consistent approach to change management with colleague engagement at its core. The strategy focuses on four behaviours, based on agreed Trust values, which the Trust expects to be demonstrated by all employees.

Formal engagement takes place with staff side representatives takes place through the Staff Management Partnership Forum which meets on a monthly basis and the Medical and Dental Pay and Conditions Committee.

We have six elected staff members on our Membership Council, all of whom are active in engaging with employees of the Trust as Foundation Trust Members and ensuring that they are involved in developing the work of the Trust.

The Well Led Organisation Group has been established to monitor and provide assurance on staff engagement and experience and the factors that contribute to this.



We also engage with our workforce directly through a range of channels and mechanisms that promote staff engagement and communication:

- Team Brief on a monthly basis, which ensures all staff receive regular updates from Executive Board meetings as well as Divisional and Departmental updates
- CHFT Weekly, an electronic newsletter for staff sharing top news stories for the week
- Our monthly staff newsletter "Trust News", which provides a lively mixture of service, performance and financial information as well as items about individual, team and Trust achievements
- Our staff intranet
- Team meetings, briefing sessions, workshops and meetings which involve the Trust's Chief Executive and other members of the Executive Team
- Colleagues have access to the Chief Executive through his weekly blog communication, which allows for an exchange of views on specific issues. There is also an opportunity for staff to meet face-to-face with the Chief Executive through scheduled sessions to find out what is happening in the Trust and its future direction. This also provides an opportunity for staff to question the Chief Executive about issues that are important to them
- 'Go See Fridays', where Executive Directors and senior staff visit clinical areas and departments to meet with staff and give them the opportunity to raise any workplace issues
- Staff suggestion scheme
- Workforce and OD Line Manager's Bulletin is published every month

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

Equality & Diversity

The Trust is committed to ensuring that it provides a high quality of service for all of its patients and is an employer of choice in the local area. It also has a legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between protected groups.

Consultation with communities of special interest in 2011 indicated that they wanted the Trust to focus on areas of improvement that fall broadly into three categories and in March 2012 the Board of Directors agreed the following high level corporate objectives:

1. Access

The Trust will demonstrate improvements in access to services for people with protected characteristics.

2. Information and communication

The Trust will demonstrate improvements in data collection, utilisation and analysis to inform service improvement for people with protected characteristics.

3. Staff attitude, behaviour and training

The Trust will deliver training programmes that reflect the need for employees to respect equality, diversity and human rights.

Underneath these three high level objectives, workstream leads for each of the protected characteristics identified in the Equality Act 2010 developed plans for action, with measurable dates and outcomes. This initially resulted in 102 individual objectives for completion during the 2012-2016 period. By December 2014, following annual reviews of the objectives, the overall number of objectives scheduled for completion before March 2016 had risen to 162. The high-level objectives have been retained for 2015-16 and further actions beneath those headings will be reviewed and determined before April each year, in line with legislative requirements.

The national NHS staff survey contains a specific question relating to equality and diversity training, against which CHFT was shown to be performing poorly in comparison with other acute NHS providers. To address this, the Trust introduced a strategy for equality and diversity training, which was endorsed by the Equality and Inclusion Group in May 2014.

The strategy underpins the programme of work required to achieve the Trust's 3rd objective around improving training provision and take-up in relation to equality and diversity and introduces 3 "levels" of training: Level 1 - Basic/Awareness (aimed at all CHFT colleagues except the Leadership team); Level 2 - Essential (aimed at colleagues working with patients with protected characteristics) and Level 3 - Expert (for the Leadership team and Directors).

During 2014 the Trust's Patient Experience and Caring Group was established. This strategic group aims to oversee and coordinate activity which is designed to improve the patient's experience whilst under the care of the Trust. Providing equitable and accessible care is one of the underlying principles of creating a good patient experience. To this end, members of the Equality and Inclusion Group are now attending the Patient Experience and Caring Group in order to help support an equitable and inclusive approach to providing an excellent patient experience.

It has been found that in terms of equality, outcomes improve for patients and staff where organisations benchmark their activity against other similar organisations. The NHS Equality Delivery System (EDS) – a framework for developing good practice in relation to equality and diversity – has now been reviewed and updated (EDS2) and from March 2016 it will be a requirement that all NHS Trusts use EDS2 to improve their equality performance.

By April of each year, the Trust is obliged to review its equality objectives as part of its specific duty to meet the requirements of the Equality Act 2010. From April 2015, this review will include an analysis of the Trust's progress towards achieving the 18 outcomes of EDS2.

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

The Care Certificate, launched in April 2014 has been incorporated into the apprenticeship programme for all new healthcare assistant roles ensuring we deliver to the standards. The Trust is looking to widening participation

through ensuring the scheme continues to support people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation in to the employment market. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing.

Attendance Management

For the period January to December 2014 the Trust's sickness absence rate was 4.5%. This figure is provided by the Health and Social Care Information Centre and is based on an average full time equivalent of 5195 employees for the calendar year. The Trust recognises that the health and wellbeing of its employees is a key determinant in safe and high quality services. High rates of absenteeism are costly, from an economic point of view as well as the impact on the morale of the workforce and the potential loss of continuity of patient care. The Trust has a policy which supports regular attendance at work that enables managers to manage attendance fairly, with a focus on rehabilitation and return to work wherever possible. For 2015/16 the Trust has set an one of its objectives under 'A workforce for the future' to launch a campaign to actively support improvements in health and well-being and reduce absence.

	2013-2014	2014-2015
F.T.E Days Lost (Long Term)	23,472.43	22,955.31
F.T.E Days Lost (Short Term)	47,800.73	54,991.93
Total F.T.E Days Lost	71,273.15	77,947.24
Available F.T.E	1,853,527.92	1,859,952.50
Percentage Staff Sickness	3.85%	4.26%



Staff Survey

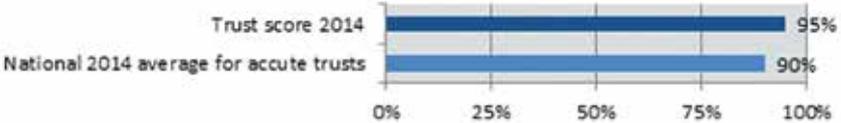
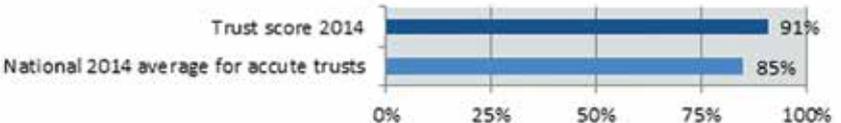
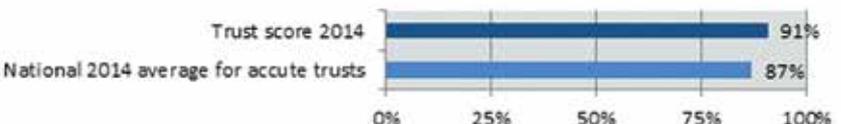
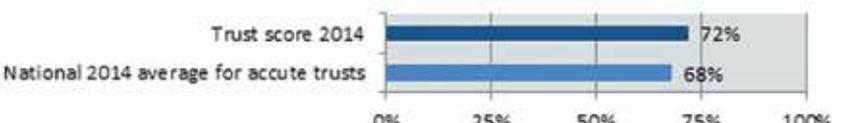
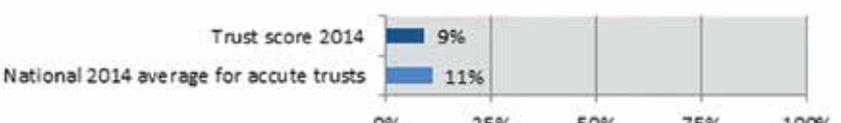
National Staff Survey

Following the publication of the national NHS staff survey results in February 2015, we intend to use this feedback to plan where we need to make improvements. Each year we produce a staff feedback and action plan based on “what you said – what we’ve done and what we’re doing”. Between October and December 2014 a random sample of 850 members of staff were asked to fill in the survey and 370 responded (45%).

The results of the staff survey in 2014 have shown that there is a lower than average score for staff experiencing discrimination at work; we are better than the national average for team working; job satisfaction; staff having opportunities to contribute to improvements at work and staff engagement. Staff recommending the Trust as a place to work or receive treatment scored as average. The Well Led Organisation Group is responsible for approving the Trust’s annual staff survey programme and associated actions to be carried out by Divisions/Corporate Functions. This will include the development of action plans to focus on areas for improvement, with regular reports to be taken to the Well Led Organisation Group who will monitor progress and implementation against the action plans.

In 2015/16 we intend to focus on initiatives to maintain our improved appraisal rates, provide staff with tools and techniques improve their health and wellbeing, improve our uptake of equality and diversity training and health and safety training.

The table below shows the response rates and the top and bottom ranking scores in the annual NHS Staff Survey 2014 in comparison to 2013.

KEY FINDING	TOP 5 RANKING SCORES
<p>KF13. Percentage of staff reporting errors, near misses or incidents witnessed in the last month <i>(higher the score the better)</i></p>	 <p>Trust score 2014: 95%</p> <p>National 2014 average for acute trusts: 90%</p>
<p>KF7. Percentage of staff appraised in last 12 months <i>(higher the score the better)</i></p>	 <p>Trust score 2014: 91%</p> <p>National 2014 average for acute trusts: 85%</p>
<p>KF27. Percentage of staff believing the trust provides equal opportunities for career progression or promotion <i>(higher the score the better)</i></p>	 <p>Trust score 2014: 91%</p> <p>National 2014 average for acute trusts: 87%</p>
<p>KF22. Percentage of staff able to contribute towards improvements at work <i>(higher the score the better)</i></p>	 <p>Trust score 2014: 72%</p> <p>National 2014 average for acute trusts: 68%</p>
<p>KF28. Percentage of staff experiencing discrimination at work in last 12 months <i>(lower the score the better)</i></p>	 <p>Trust score 2014: 9%</p> <p>National 2014 average for acute trusts: 11%</p>

KEY FINDING	BOTTOM 5 RANKING SCORES
KF17. Percentage of staff experiencing physical violence from staff in last 12 months <i>(lower the score the better)</i>	<p>Trust score 2014: 4%</p> <p>National 2014 average for acute trusts: 3%</p>
KF26. Percentage of staff having equality and diversity training in last 12 months <i>(higher the score the better)</i>	<p>Trust score 2014: 45%</p> <p>National 2014 average for acute trusts: 63%</p>
KF16. Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months <i>(lower the score the better)</i>	<p>Trust score 2014: 17%</p> <p>National 2014 average for acute trusts: 14%</p>
KF14. Fairness and effectiveness of incident reporting procedures <i>(higher the score the better)</i>	<p>Trust score 2014: 3.50</p> <p>National 2014 average for acute trusts: 3.54</p>
KF10. Percentage of staff receiving health and safety training in last 12 months <i>(higher the score the better)</i>	<p>Trust score 2014: 74%</p> <p>National 2014 average for acute trusts: 77%</p>

Staff Friends and Family Test

Our NHS Staff Friends and Family Test results from Quarter 2 in August 2014 shows 398 colleagues participated in the survey, which asks two questions and provided an opportunity to give comments:

1. Would you recommend us to your friends and family as a place to receive treatment?

– 81% of staff said yes (82% in the Q1 survey)

2. Would you recommend us to your friends and family as a place to work?

– 59% of staff said yes (67% in the Q1 survey)

The Trust will use the anonymised comments to identify any concerns from staff and by engaging with staff look at ways we can make local improvements.



Learning and Development

In 2014/2015 the Trust built on its colleague engagement strategy which has at its core the four behaviours that we expect to see across the organisation.

The Trust strengthened its commitment to having a consistent approach to how it manages change and in particular how we manage change that fully engages the potential and creativity of staff and allows colleagues to work across divisional and organisational boundaries. A programme of activity was initiated and our Work Together, Get Results (WTGR) programme which explores simple and practical tools that helps leaders engage colleagues in a way that allows breakthroughs in their ability to lead transformational change in the organisation. Properly applied, the tools secure the commitment of colleagues to the organisation's results and values and ensure colleagues are motivated and contribute to delivering the Trust vision. The programme provides individuals and teams with a comprehensive toolkit which when applied consistently has the capacity to transform the way we work and create an environment where ideas from all parts of the organisation are taken on board and improvements made. Since the inception of the WTGR programme 221 colleagues have attended the two day foundation programme and 109 coaching circles have been successfully completed.

Many colleagues also take up the opportunity to maximise their potential and achieve the things that are important to both themselves and the trust through accessing individual coaching with one of our trained coaches. Coaching circles are active across the organisation to enable and support cross divisional learning and support for colleagues to respond effectively to the difficult challenges that arise.

An internal consultant mentoring programme has been established and is running successfully for new consultants into post ensuring they have the support and guidance they need to be fully effective, efficient and confident in their role as soon as possible and to enhance their clinical leadership skills and behaviours.

We have a number of trained NHS Leadership Framework 360 feedback facilitators and qualified Myers Briggs Practitioners in the Trust who are able to give additional support to colleagues wishing to develop their leadership skills and behaviours further and gain greater insight into themselves. These activities are also offered as standard within our leadership development programmes.

During the year we have also trained a further cohort on our leadership development programme, the ninth since the programme's inception, using our modular CHFT Leadership passport. The managers in the cohort have followed a twelve month pathway to equip them with pragmatic, easy to use workplace tools to enable them to best manage and support their teams and the organisations goals. The pathway will be refreshed or the coming year to meet the new challenges the NHS faces.

We are currently looking to re-design our clinical director leadership development programme and work is underway to create an offer that meets the needs of our senior clinical leaders.

The Trust has supported colleagues in the various NHS Leadership Academy Professional Programmes on offer.

We continued to deliver real improvement in our appraisal compliance and during 2014/2015 achieving 92% for non-medical and medical colleagues against an internal target of 100%. Appraisals are seen by the Trust as a key contact with colleagues and an opportunity to engage them in what the organisation's goals are. Work now focuses on ensuring the appraisal interaction is of high quality and we will test colleagues' experience of the appraisal tool and the conversations that take place in the appraisal setting to improve our approach.

Our overall approach to mandatory training is also being refreshed for 2015/2016 to embrace the Core Skills Training Framework. This a national approach that embraces a blended approach to maximise colleagues opportunity to learn whilst ensuring essential learning outcomes are met. This will enable us to build on our current compliance of 70%.

The apprenticeship route for Healthcare Assistant (HCA) recruitment continues to prove successful. Two cohorts have now completed will all participants securing a Band 2 HCA post or going on to undertake further training. This approach ensures a qualified individual who is given the required support and encouragement resulting in competent, compassionate team members. The approach also meets the requirements of the Cavendish Care Certificate launched in April 2015 will all HCA Apprentices appointed from March 2015 completing the Care Certificate as part of their programme. The March 2015 cohort includes a pilot of 6 Therapy Support Apprentices and two Phlebotomy Apprentices. The vocational team are also working with Kirkwood Hospice to support 2 of their HCA's to complete the Cavendish Care Certificate.

Significant learning opportunities were provided during the past year for non-clinical colleagues through a clustered agreement with other local health and social care organisations. The cluster working models maximises the benefit achieved by pooling learning and driving down delivery costs while enhancing the shared learning benefits.

The Trust is working with leading whistleblowing charity, Public Concern at Work (PCaW), to provide opportunities for colleagues to raise concerns about any matter that occurs in the workplace and for them to be appropriately managed and resolved. The Trust takes the issue of raising concerns very seriously and recognises the importance of creating an environment where colleagues are encouraged to raise concerns at work. As part of the work we are doing with PCaW, staff now have direct access to the PCaW helpline and email address. The Trust has also signed up the PCaW's "First 100" campaign. This commits employers in both public and private sectors to abiding by PCaW's Code of Practice on Whistleblowing.

Occupational Health

The Occupational Health department's overall function is to ensure the health and wellbeing of all colleagues working for the Trust, with specific regard to the relationship between health and work. Their aim is to keep staff healthy and happy in work - and by doing so, to protect and ensure the best possible service to patients. The department has maintained full accreditation to Safe Effective Quality Occupational Health Standards (SEQOHS) since December 2013. The Standards measure that the Occupational Health Department meets minimum requirements, reflecting existing ethical and professional guidance and consensus and helps them achieve uniform good practice. The Occupational Health Department has a strong focus on the health and well-being of staff and, works with local partnerships and networks to focus on initiatives such as becoming a smoke free Trust, support for staff and managers on mental health pathways and reducing the impact of musculoskeletal conditions.

2015 has been designated as the Year of Wellbeing with a number of activities and events being held throughout the year. The Trust is working with colleagues on improvements which impact positively on the health and wellbeing of all of our staff. The wellbeing of our employees is important to ensure that we continue to provide high quality patient care, supported by good management practices and engage staff in key decisions which affect their health and wellbeing. A number of initiatives to support the strategy have been put in place including:-

- Training for managers on undertaking stress risk assessments
- Training for staff on managing stress and promoting mental wellbeing
- A visible presence of workforce wellbeing with a calendar of events promoting the year of Health and Wellbeing, embracing the "back to the floor" programme and generating colleague engagement.
- A quarterly Wellbeing Bulletin is available for all staff
- An intranet wellbeing programme to be made available to all staff, their families and friends, incorporating a mobile phone wellbeing application.
- A network of champions to be recruited to lead on a particular health interest or in a geographical area, to promote the health and wellbeing messages

Volunteers

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

Stakeholders

As part of its governance review in 2013, we undertake a stakeholder feedback survey to better understand our relationship with many of our stakeholders and how this could be developed further. Effective relationships with all of our stakeholders enables us to maximise the benefits to patients and have open and honest dialogue during challenging times. We have continued to strengthen our relationships with all of our stakeholders throughout 2014/15, in particular commissioners, our local authorities and the local HealthWatch organisations.

We are a key partner on the local Urgent Care and System Resilience Boards. We have representation on our Membership Council from both of our local authorities, the University of Huddersfield, Locala (a local community provider) South West Yorkshire Partnership Foundation Trust (the mental health care provider) and a single representative on behalf of both clinical commissioning groups.

Over the last year we have established stronger working relationships with the GP federations in both Calderdale and Kirklees and successfully developed services and pathways of care between primary and secondary care as a result. Our clinical leaders have also been working with GP commissioners on the future development of hospital services and pathways of care through community and acute services.

We have continued to have an open and honest relationship with HealthWatch and the Overview and Scrutiny Committees. We have engaged with them early on issues facing the Trust or in the development of plans to make changes in services. HealthWatch have also worked with our Membership Councillors on how to engage with and seek the views of the public.

Directors' declaration

All directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware. All directors have taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

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

Our Board of Directors

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

Andrew Haigh Chairman

Appointment: 7.7.2011 to 6.7.2017

Andrew was appointed as Chairman of the Trust in July 2011. He trained locally as a chartered accountant with Armitage & Norton and moved to KPMG in Leeds when the two firms merged in 1987. He specialised in IT risk management and audit, particularly within retail financial services and the public sector eventually leading the IT Advisory practice for the KPMG in the UK and the Financial Services practice in the North of England. He retired from KPMG in 2008 to care for his wife who has a long term degenerative illness and became a Non-Executive Director of the Trust in December 2010. He is also a Non Executive Director at Furness Building Society in Barrow. Andrew has lived in Huddersfield all his life.



Owen Williams Chief Executive

Permanent post

Owen joined Calderdale and Huddersfield NHS Foundation Trust as Chief Executive in May 2012. Working with doctors, nurses, therapists, porters and partners, Owen is keen to ensure that compassionate care is provided for the 458,000 people in the Trust's catchment area and beyond. Prior to joining Calderdale he was Chief Executive of Rossendale Council and before that he worked in the commercial sector across Financial Services, Telecommunications and Marketing. He has also worked with the Department of Health as part of its original Strategic Health Authority assurance process and was Joint Chair and Local Authority lead on the National Mental Health Strategy Board – No Health without Mental Health.



Julie Dawes Executive Director of Nursing and Operations / Deputy Chief Executive

Permanent post

Julie joined the Trust as Director of Nursing in April 2014. Previously Chief Nurse at Portsmouth NHS Trust, Julie brings a wealth of expertise in patient safety, patient experience and quality. Julie is originally from Hebden Bridge and has worked in hospitals in Leeds, Southampton and Portsmouth. Julie has a clinical and managerial background in cancer and palliative care. She has particular areas of expertise in developing



improvement programmes for patient experience and safety. She is an experienced leader who demonstrates an open and honest, but tenacious approach, and has a very high level of personal drive and commitment. Julie has recently completed the Kings Fund Stretch to the Board programme and has been identified as one of the 100 leaders chosen to attend the Top Leaders Programme being led by the National Leadership Council.

Keith Griffiths Executive Director of Finance

Permanent post

As Finance Director Keith shares the accountabilities of any executive director regarding patient safety, organisational performance and governance. As the qualified accountant on the Board, Keith has personal responsibility for the strategic financial planning and reporting of the Trust, the running of the finance and procurement teams contract negotiations with commissioners, capital financing arrangements and the provision of an internal audit and fraud service.



Lesley Hill Executive Director of Planning, Performance, Estates and Facilities

Permanent post

Lesley has worked as a director of the Trust for 9 years taking responsibility for a number of different areas. Currently Lesley leads and advises the Board on the development of the annual plan to satisfy the requirements of Monitor, supporting clinical divisions in the development of business plan; ensures a fit-for-purpose performance framework is developed and embedded across the organization; and is responsible for the leadership and delivery of the Estates and Facilities services on all sites, including Emergency Planning.



Julie Hull Executive Director of Workforce and Organisational Development

Permanent post

Julie leads the development and delivery of the workforce and organizational development strategies to ensure they meet their aims, values and objectives and that these are implemented in a cost effective, timely manner in support of the organisation's strategic planning, governance, corporate policy making and overall Trust objectives.



David Birkenhead Executive Medical Director

Permanent post

As Medical Director, David shapes and leads the clinical services delivered by the Trust in order to drive the best health outcomes. Current large scale projects include reviewing how the Trust delivers care across the community and the hospitals, the development of 7 day services, and the implementation of



an electronic patient record. The Medical Director provides a professional lead for allied health professionals and medical staff and as the Trust's Responsible Officer makes recommendations to the General Medical Council around medical revalidation. David also takes the lead on education and training, research and development and infection control.

Jan Wilson

Non-Executive Director / Vice Chairman

Appointment: 1.12.2011 to 30.11.2017

Jan lives in the Holme Valley and has a background in strategic planning, commissioning and inspection in health and social care services. She has a management qualification and worked for Kirklees and Calderdale local authorities before moving to the West Midlands and the Mersey region to implement the NHS and Community Care Act and the Children Act. She was a Non-Executive Director with Calderdale and Kirklees Health Authority, Deputy Chair at South West Yorkshire Mental Health Trust and Senior Independent Director when it became South West Yorkshire Partnership NHS Foundation Trust (SWYPFT). Current positions include Lay Chair for junior doctor recruitment and training with Yorkshire and the Humber Post Graduate Deanery, Non-Executive Director at Groundwork, Wakefield, Associate Hospital Manager at SWYPFT and Ambassador for Public Appointments with the Government Equalities Office. Jan is currently Deputy Chair of the Trust.



Dr David Anderson

Non-Executive Director/SINED

Appointment: 23.9.2011 to 22.9.2017

David is a GP at the Grange Group Practice, Fartown, where he has worked since 1983. He is past Chairman of both the former Huddersfield Central and NHS Kirklees Professional Executive Committees. He was involved in commissioning hospital services, until he stepped down in June 2011. David was brought up in West Yorkshire and has lived in Halifax and Huddersfield since 1980. He is married to a health visitor and has three children. He enjoys cycling, running and tennis. David is committed to developing and delivering services in Calderdale and Huddersfield and recognises the benefits of more integration across hospital, primary care and local authority services. David is the Senior Independent Director and is a member of the Charitable Funds Committee.



Professor Peter Roberts

Non-Executive Director

Appointment: 23.9.2011 to 22.9.2017

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



he is involved in a range of regional and urban planning, regeneration, housing and health, economic development and environmental management. Peter has acted as an advisor to the House of Commons Children's, Schools and Families Select Committee and to Local Government. He has been involved in community regeneration projects in Tyneside, Merseyside, Greater Manchester, West Yorkshire and elsewhere. He was awarded the OBE in 2004 for services to regeneration and planning. Peter is the Chair of the Trust's Audit and Risk Committee.

Dr Linda Patterson

Non-Executive Director

Appointment: 1.10.2013 to 30.9.2016

Dr Linda Patterson OBE lives in Hebden Bridge and is a consultant physician in general and geriatric medicine. She worked in clinical practice at the East Lancashire Hospitals Trust. She has been a clinical director, Trust Medical Director, and was medical director of the first NHS regulator, the Commission for Health Improvement. She has also been a non-executive director for the National Patient Safety Agency. She has recently stood down as the clinical vice-president of the Royal College of Physicians. She is passionate about improving quality of care, particularly using patient experiences to drive up quality. Linda is a member of the Quality Committee.



Jeremy Pease

Non-Executive Director

Appointment: 1.10.2013 to 30.9.2016

Jeremy has worked for the NHS for over 30 years in Human Resource and Operational Management roles in acute, community and mental health organisations and the ambulance service. Since 2007 he has been self employed and runs his own management consultancy. Jeremy is married, has two sons and lives in Shepley. Jeremy is Chair of the Quality Committee and a member of the Audit and Risk Committee.



Philip Oldfield

Non-Executive Director

Appointment: 23.9.2013 to 22.9.2016

Phil is a Chartered Accountant and MBA and he has a wide range of senior management experience within Retail, Manufacturing, Healthcare and Consultancy. He has over 15 years experience at Board level and has held a number of senior management roles in Logistics, IT and Operations. Previous Healthcare experience includes Finance and Commercial Director for Nuffield Hospitals, Finance Director for Health and Social Care in Guernsey and a number of consultancy projects across the NHS. Phil has also recently taken up the role of Finance Director for the Sue Ryder Charity. Phil grew up in the Huddersfield area. Phil is Chair of the Finance and Performance Committee and is a member of the Audit and Risk Committee and Charitable Funds Committee.



Appointment and removal of non-executive directors

Appointment, re-appointment and, if applicable, removal of non-executive directors is the responsibility of the membership council. Appointments are usually for a three-year term. The process for appointments and re-appointments is overseen by the nominations committee of the council which makes recommendations on the appointment to the full council. The procedure for removal of the chair and other non-executive directors is laid out in the constitution which is available on our website or on request from the Company Secretary.

Division of responsibilities

There is a clear division of responsibilities between the Chairman and the Chief Executive. The Chairman ensures the board has a strategy which delivers a service that meets and exceeds the expectations of the communities we serve and that the organisation has an executive team with the ability to deliver the strategy. The Chairman facilitates the contribution of the non-executive directors and their constructive relationships with the executives. The Chief Executive is responsible for leadership of the executive team and for implementing our strategy and delivering our overall objectives, and for ensuring that we have appropriate risk management systems in place.

Declaration of interests

All directors have a responsibility to declare relevant interests, as defined within our constitution. These declarations are made to the Company Secretary, reported formally to the board and entered into a register which is available to the public. The register is also published on our website, and a copy is available on request from the Company Secretary.

Independence of directors

The non-executive directors bring strong, independent oversight to the board and all non-executive directors are currently considered independent. We are committed to ensuring that the board is made up of a majority of independent non-executive directors who objectively challenge management, balanced against the need to ensure continuity on the board. The board strongly believes that continuity of corporate knowledge and experience is important to complement and support the new skills and experience brought to the board by those directors appointed over the last two years.

A recommendation to reappoint a non-executive director beyond six years would follow detailed scrutiny by the committee to ensure the continued independence of the individual director and with due regard to the need to progressively refresh the board. Non-executive directors who are appointed beyond six years would always be subject to annual reappointment. Reviews would take account of the need to progressively refresh the board whilst ensuring its stability. Provisions regarding the independence of the non-executive director will be strictly observed.

During 2014-15 there were no reappointment decisions required of the nominations committee and there are currently no non-executive directors who have served more than six years on the Board.

Attendance summary

NAME OF DIRECTOR	BOARD OF DIRECTOR MEETINGS ATTENDED
A Haigh (Chair)	12/12
D Anderson	10/12
P Oldfield	10/12
L Patterson	11/12
J Pease	09/12
P Roberts	11/12
J Wilson	11/12
O Williams	12/12
B Crosse	02/02 (RESIGNED June 2014)
D Birkenhead	09/10 (COMMENCED June 2014)
J Dawes	10/12
K Griffiths	11/12
L Hill	11/12
J Hull	09/12

Notes:

There were 11 routine board meetings and 1 Joint Annual General Meeting with the Membership Council.

Evaluating performance and effectiveness

Each year, the board undertakes a review of its performance and effectiveness, and this provides a useful opportunity for the board to take a step back and reflect. In previous years, approaches such as questionnaires and facilitated workshops have been used.

During 2013 the board commissioned Foresight Partnership to undertake an external review of its governance. The board considers the review to be independent because Foresight Partnership do not have any other connections with us and have not undertaken any similar work for us in the last five years. Recommendations from this review were implemented and are being embedded within the organisation. In 2015/16 the Board will complete its Well Led Governance Review which will be independently reviewed by Price Waterhouse Coopers and a report presented to the Board in June 2015.

In addition, the Audit and Risk Committee undertook an internal review of effectiveness in September 2014 and this resulted in a recommendation that the terms of reference for all board committees be reviewed to ensure that they remain fit for purpose and there are no areas of overlap.

A robust appraisal process is in place for all board members

and other senior executives. The Chairman appraises the Chief Executive, and the chief executive carries out performance reviews of the other executives. All these reports are available to the membership council.

The Chairman undertakes the performance review of non-executive directors using the Trust's appraisal documentation and the outcomes of these appraisals are reported to the membership council. During 2014-15, the performance review of the chairman was led by the senior independent non-executive director in accordance with a process agreed by the membership council. All membership councillors are invited to contribute to the appraisal process for the chairman. The outcome was then reported to the council by the senior independent non-executive director.

Understanding the views of membership councillors and members

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

If you would like to make contact with a director or one of our membership councillors please contact the Board Secretary

Also available on our website: Register of Interests, Statement on the division of responsibilities between the Chairman and Chief Executive.







Governance report

Our Membership Council

Our Membership Council

Overview

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

The Membership Council comprises 16 publically elected, 6 staff elected and 6 nominated stakeholder councillors.

Membership Councillors are broadly representative of the population that the Trust serves. They listen to the views and ideas of the Trust's membership and of the wider public. In turn, the Trust offers a range of events and opportunities for the Membership Councillors to share those views and engage with the board of directors in order to influence strategy and develop services for patients.

Elections

In order to refresh the Membership Council and bring a diverse range of views into the Trust, elections are held every year. These elections are held in the various geographical or staff constituencies of the Trust. During 2014 the following elections were made with each member being offered a 3 year term with effect from 18 September 2014:-

CONSTITUENCY	NAME	RE-ELECTED/ELECTED	ELECTION TURNOUT
Constituency 3	Peter Middleton	Re-elected unopposed	Unopposed – N/A
Constituency 5	George Richardson	Elected unopposed	Unopposed – N/A
Constituency 6	Brian Richardson	Elected unopposed	Unopposed – N/A
Constituency 7	Lynn Moore	Elected	Turnout 11.1%
Constituency 7	Kate Wileman	Re-elected	Turnout 11.1%
Constituency 9	Dr Mary Kiely	Re-elected unopposed	Unopposed – N/A

Committees and working groups

Once elected, Membership Councillors are invited to get to know the Trust and its staff through a range of committees and groups. These are:

Membership Council meetings

The full Membership Council meets formally four times a year, plus the AGM. The meetings are attended by board directors as well as Membership Councillors and standing agenda items include business planning, service developments, quality and the Trust's financial position. These meetings include non-executive director observers.

Trust Board meetings

Trust Board meetings are held monthly. Two Membership Councillors are invited to attend as observers. An opportunity is given to Membership Councillors to share any comments or observations.

Membership Council Sub-committees

These groups include the Remuneration & Terms of Service sub-committee; the Nominations sub-committee; the AGM planning sub-group; the Audit & Risk committee; the Finance and Performance committee; the Charitable Funds committee and the Organ Donation committee.

Divisional Reference Groups

Membership Councillors and Trust colleagues are able to share and debate issues around patient care at divisional reference group meetings (DRGs). The DRGs cover the four clinical divisions and Estates and Facilities. The meetings are chaired by a Membership Councillor who sets the agenda for each meeting in collaboration with senior divisional staff. The meetings are attended by fellow Membership Councillors and discuss divisional business planning, divisional priorities, finances, performance and any service developments. In addition to participating in these DRGs, staff Membership Councillors also meet separately as a group four times a year, and share ideas with the Trust chief executive and Trust chairman respectively.

Chair's Information Exchange

Each DRG chair attends a quarterly 'chairs information exchange' meeting. The Trust chairman is informed of the discussions and decisions of the respective divisional reference groups and is able to update attendees on Trust issues and priorities. This information exchange helps to inform the agenda of both the Membership Council meetings and the Trust board meetings

Board and Council communications

Membership Councillors and members of the board of directors meet and share views on Trust strategy and future developments. In addition to the groups and committees already outlined, they discuss topical issues at joint workshops with the full Trust board, and separately with the non-executive members of the board. The Chairman meets with the Membership Council in private before each full Council meeting. Directors routinely attend meetings

of the Membership Council and representatives of the Membership Council attend board of director meetings. The Membership Council receives the Integrated Board Report at each of its meetings presented by the Director of Planning, Performance, Estates and Facilities, the Director of Finance and the Director of Nursing. Similarly, the Membership Council receives minutes and papers of the monthly board of director meetings together with the monthly Integrated Performance Report.

Declarations of interests

All Membership Councillors have a responsibility to declare relevant interests as defined in our Constitution. These declarations are made to the Board Secretary and are reported to the Council and entered into a register. The register is maintained by the Foundation Trust Office, and is available on the Trust website or by contacting the office on 01484 355933.

MEETING DATES		8.4.14	9.7.14	18.9.14 AGM & HEALTHFAIR	6.11.14	20.1.15	TOTAL ATTEND-ANCE
PUBLIC – ELECTED							
1	Mrs Joan Doreen Taylor	x	x	x	x	x Resigned 3.2.15	0/5
1	Mr Martin Urmston (Deputy Chair from 18.9.14)	x	√	√	√	x	3/5
2 (RESERVE REGISTER)	Mrs Linda Wild	√	√	x	√	x	3/5
2	Rev Wayne Clarke	√	√	√	√	√	5/5
3	Mr Peter John Middleton	√	√	√	√	x	4/5
3	Ms Dianne Hughes	x	√	√	x	√	3/5
4	Mrs Marlene Chambers	√	√	x	x	√	3/5
4 (RESERVE REGISTER)	Mrs Liz Schofield	√	x	√	x	√	2/5
4	Mrs Chris Breare	√	√	√	Tenure ceased 18.9.14		
5	Mr Grenville Horsfall	√	√	x	x	x	2/5
5	Mr George Edward Richardson	-	-	Commenced 18.9.14 √	√	√	3/3

MEETING DATES		8.4.14	9.7.14	18.9.14 AGM & HEALTHFAIR	6.11.14	20.1.15	TOTAL ATTEND-ANCE
5 (RESERVE REGISTER)	Mr Bernard Pierce	x	√	x	Tenure ceased 18.9.14	-	1/3
6	Mrs Johanna Turner	√	x	x	√	√	3/5
6	Mr Brian Richardson	-	-	Commenced 18.9.14 √	√	x	2/3
6 RESERVE	Mrs Janette Roberts	√	√	√	Tenure ceased 18.9.14		3/3
7	Ms Kate Wileman	x	x	√	√	x	2/5
7	Mrs Lynn Moore	-	-	Commenced 18.9.14 √	√	√	3/3
8	Mr Andrew Sykes	x	x	x	x	√	1/5
STAFF – ELECTED							
9 - Drs/Dentists	Dr Mary Kiely	x	x	x	x	√	1/5
10 - AHPs/HCS/ Pharm's	Miss Avril Henson	√	√	√	√	√	5/5
11 - Mgmt/Admin/ Clerical	Mrs Eileen Hamer	x	√	√	x	√	3/5
12 - Ancillary	Miss Liz Farnell	√	√	√	√	x	4/5
13 - Nurses/ Midwives	Mrs Chris Bentley	√	x	√	x	√	3/5
13 - Nurses/ Midwives	VACANT POST	-	-	-	-	-	-
NOMINATED STAKEHOLDER							
University of Huddersfield	Prof John Playle	x	√	√	x	√	3/5
Calderdale Metropolitan Council	Cllr Bob Metcalfe	√	√	√	√	√	5/5
Kirklees Metropolitan Council	Cllr Hilary Richards	-	-	Commenced 18.9.14 √	√	√	3/5
Clinical Commissioning Group	Mr David Longstaff	-	-	Commenced 18.9.14 x	x	x	0/3
Locala	Mrs Janice Boucher	-	-	Commenced 18.9.14 √	√	x	2/3
South West Yorkshire Partnership NHS FT	Mrs Dawn Stephenson	x	x	x	x	x	0/0
NHS Calderdale CCG	Mrs Sue Cannon	x	x	x	Tenure Ceased 18.9.14	-	0/3
NHS Kirklees CCG	Mrs Jan Giles	x	x	x	18.9.14	-	0/3

Councillor training and development

Membership Council Induction

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

Membership Councillor Training Programme

Following induction, Membership Councillors are invited to attend a series of training offerings. These are designed to extend Councillors' knowledge of the Trust and the wider NHS in order to help them contribute to discussions on Trust strategy and planning. These interactive and informative sessions are delivered by subject experts and cover such topics as 'Understanding Quality in the NHS', 'An Introduction to NHS Finance', 'Improving the Patient Experience'. We've developed a new session called 'Holding to Account'. This supports our Membership Councillors to feel more confident in their role of holding non-executive directors to account for the performance of the board.

Membership Council Development Days

The Trust has devised a programme of four development sessions for Membership Councillors. These sessions are attended by Membership Councillors, the Trust chairman and respective board directors. An 'open space' discussion is always included where Membership Councillors debate current key challenges and opportunities. These debates and discussions help to shape future Trust plans.

Governance

In addition to formal meetings and committees, Membership Councillors contribute to the good governance of the Trust in a variety of other ways:

Chairman's One-to-One meetings

Each newly elected or appointed Membership Councillor is offered the opportunity to meet with the Trust chairman on a one-to-one basis. These meetings help to set expectations, detail the support that is available, and clarify the role of the

Membership Council. In addition, the Trust chairman meets quarterly with the deputy chairman of the Membership Council.

Quality Accounts

Each year, members and Membership Councillors are asked to help the Trust to decide upon its priorities for quality improvement. A list of quality indicators is presented and explained. Membership Councillors discuss the priorities and are invited to give their views on these or to add their own suggestions. Members and Membership vote on the suggested improvement indicators, and progress on them is published in the Trust's Quality Accounts.

Approval of Annual Plan

A draft version of the Trust's annual plan is shared with Membership Councillors. An extraordinary meeting provides an opportunity for Membership Councillors to review and comment upon divisional proposals and the Trust's overall plans. At the meeting, the Membership Councillors are asked to give their agreement to the finalisation of the annual plan.

Mock CQC inspection visit

This year, Membership Councillors were invited to join a multi-disciplinary team to help conduct a mock inspection visit using Care Quality Commission standards. This mock inspection and subsequent report led to a rigorous action plan in order for the Trust to be fully prepared for any future official inspection visits.

Expenses claimed by Councillors during 2014/15

Membership Councillors do not receive payment for their work with the Trust, however we do have a policy for reimbursement of any necessary expenditure while on Trust business. During 2014/15 the following expenses were claimed:

	2014/15	2013/14
Total number of Councillors	28	28
Total number of claiming expenses	5	5
Total amount of expenses claimed	£229.85	£579.83

7. Our membership

Overview

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

- Find out more about the hospitals, our community services, the way they are run and the challenges they face
- Help us work with local people to improve the care and experience of patients and their carers
- Elect representatives to the Membership Council

Public membership is open to people aged 16 or over who is or has been a patient or carer at Calderdale and Huddersfield NHS Foundation Trust, or who lives within our defined membership area; or who works at the Trust

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

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

Our membership as at March 31st

Calderdale & Huddersfield NHS Foundation Trust Membership Numbers as at 31/03/2015

Group	Constituency	Number
Public	1	609
	2	1942
	3	1221
	4	512
	5	1212
	6	730
	7	1411
	8	2111
Staff	9 Doctors/dentists	440
	10 AHPs/NCS/Pharmacists	792
	11 Mgmt/Admin/Clerical	1243
	12 Ancillary	1683
	13 Nurses/midwives	1898

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

Membership Strategy

We work to make sure that we have an engaged membership which is broadly representative of the communities that we serve. Our membership strategy underpins this. Over the previous year we have:

- Actively maintained a comprehensive and confidential database of membership details. This has helped us to send targeted surveys and questionnaires to gather members' views. For instance, through this method, members have helped us to improve our written information about 'end of life care' for patients; and have given their views on the wording for a poster warning of the dangers of driving whilst under the influence of drugs.
- Worked closely with local schools and colleges to encourage younger people to join as members and enjoy the benefits. These include being able to come along to lecture talks about clinical subjects to help inform their studies.
- Completed a total overhaul of the business systems and processes in the Membership Office. This has helped us to become more efficient in responding to members' needs.

What's new this year?

During 2014 -15 we have been able to include some new developments. We've changed our constitution in order to allow us to include electronic voting in future Membership Council elections. By including electronic as well as postal voting in future elections, this will help us to improve member participation whilst also reducing our costs.

We've revamped our communications to the Membership Council. Councillors now receive an e-newsletter along with their calendar of events to keep them informed and included in key events and meetings.

What have people been involved with?

The Trust engages and communicates with its membership throughout the year. Here are some examples:

- Twice a year 'Foundation News' is published and distributed to all of the Trust's members. Through this, members get to learn about Trust services for patients, the work of their Membership Council and about forthcoming events.
- A series of popular talks is delivered by Trust colleagues. The 'Members' Forum' topics provide an opportunity for members to learn about important or innovative developments in patient care. This year, topics included 'A Day in the Life of an Anaesthetist' and 'A Day in the Life of a Junior Doctor'.
- Members are involved in helping us to gather the views of patients. 'Real Time Patient Monitoring' interviews are held once patients have completed their care and are ready to go home. These short interviews help us to understand how patients feel about being in our care and about how we can make improvements
- The views of members and Membership Councillors are an important element in the recruitment process for senior Trust clinical staff. Membership Councillors and members are invited to be part of the patient and user panels for the appointment of new consultants, senior nurses and senior non-clinical staff.
- Trust members volunteered to be part of a 'walkabout' of the phlebotomy department of HRI. Volunteers offered suggestions about how things could be improved in this important service.
- A wheelchair using member helped 'test drive' a new proposed floor plan for the in-house branch of WH Smiths at Calderdale Royal Hospital. A mock up of the proposed layout was created and then tested for accessibility.
- Members worked closely with Calderdale HealthWatch to survey visitors' attitudes to car parking facilities at CRH.
- A 'Members' Questions Inbox' has been created to enable members to pose questions directly to the chief executive or Trust chairman. Similarly, members can contact the Membership Councillors via the Trust's public website.

How to get in touch

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

Elected Council Members

Membership Council – Public Constituencies



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

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

Quality Report 2014/15



Quality Report 2014/15

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Part 1

Chief Executives' Statement

Welcome to the 2014/15 Calderdale and Huddersfield NHS Foundation Trust Quality Report.

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

Providing 'Compassionate Care' and putting our patients first continues to be a high priority for all of our staff and the Trust. We are determined to ensure that patients get the care they need, when they need it and from the right person.

By no means does the report cover everything we are doing to constantly improve the quality of our services for our patients and their families. It is intended to give you a snapshot of where we are doing well and the areas that we continue to focus on.

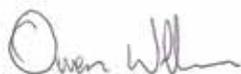
The quality of care people receive across the NHS remains high on the national agenda and there have been a number of high profile reports over the last year setting out what organisations like ours can learn from these incidents. We always take this as an opportunity to reflect on what we are doing locally and look to see where we can make improvements. We also use the feedback we receive through a variety of routes from our patients, their families and carers on what we can do to develop our services further and how we need to change them to meet the needs of our communities in the future.

Quality of care is top of the agenda for our Board of Directors and in this challenging financial environment it is even more important to ensure that any changes we make are assessed for their impact on quality before they are able to go ahead.

There are some excellent examples of high quality care and services across all of our community and hospital services. There are also areas where we know we need to do better. We will continue to share good practice and make improvements so that all our patients receive high quality compassionate care whenever, and wherever, they access our services

I hope you will find the following pages informative and helpful in giving you an insight into the vast amount of improvement work we continue to do in the Trust.

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



Owen Williams
Chief Executive
28 May 2015

Part 2

How the Trust performed against the four priorities set for 2014/15

Last year the Trust identified five quality improvement priorities for 2014/15. This section of the Quality Report shows how the Trust has performed against each of these priorities.

Improvement priority	Were we successful in 2014/15?
To improve the quality of the care we provide as measured by the Hospital Standardised Mortality Rate (HSMR)	Yes
To ensure intravenous antibiotics (IV) are given correctly and on time	Partially
Improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital	Yes
To help patients with long term pain develop the skills needed to manage their condition through supported self-management courses	Yes



Priority one: To improve the quality of the care we provide as measured by the Hospital Standardised Mortality Rate (HSMR)

HSMR is a high level outcome measure that can be used for tracking the quality of care provided. For this reason the Trust's Care of the Acutely Ill Patient (CAIP) Programme uses this as one of its measures to track progress.

HSMR - What is it?

Hospital Standardised Mortality Rate (HSMR) is a standardised measure of mortality produced by Dr Foster Intelligence (DFI). The rate is the number of actual deaths divided by the number of predicted deaths for the Trust's patients treated.

A rate of 100 means expected number of deaths matched actual number of deaths. Above 100 means we had more than expected, less than 100 means we had less than expected. The 100 benchmark is calculated based on mortality rates for all acute hospitals in England and Wales.

The CAIP programme was revised in August 2014; this resulted from the need to re-focus to areas which will lead to the biggest benefits.

This programme now consists of eight domains:

1. Reducing mortality (overall outcome measures)
2. Ensuring the recognition and prompt treatment of our deteriorating patients.
3. Delivering high standards of care through reliable delivery of care bundles.
4. Improving the care delivered to frail and elderly people.
5. Effective (focus on the courage to put patient first programme).
6. Focus on summary hospital-level mortality indicator (SHMI) conditions of interest. This is a similar measure to HSMR but focuses on specific conditions such as stroke.
7. The well led organisation.
8. Improving depth of coding.

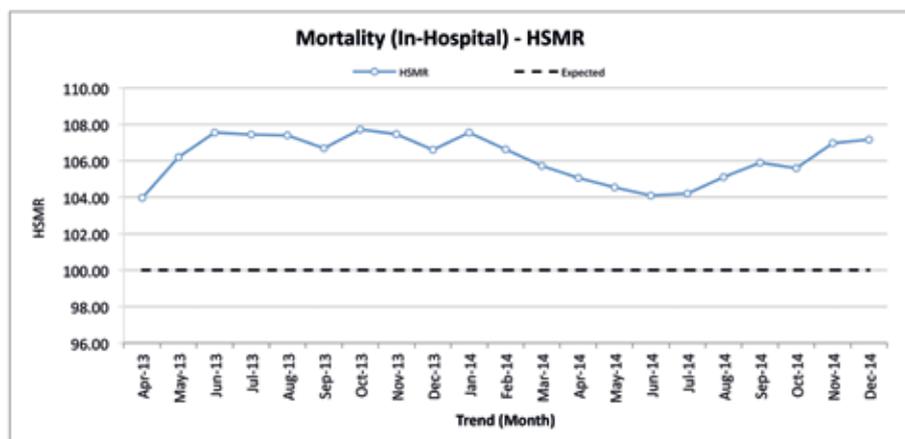
a. Target

The priority aimed to see a 10 point drop in HSMR from the 12/13 position of 104 to 94 by September 2014.

b. Achieved year to date

Data released for the period of July 2013 – June 2014 indicated that our HSMR was 92.08 against our own baseline of 104 (relating to April 12 to March 13). However the national HSMR at this time was 87.25. Therefore the national rate was showing greater improvement than that of the Trust.

If the Trust data is plotted against the national rate (the median always remains as 100), the pattern in the data can be seen in the chart below. There was an initial fall in line with the original target date of September 14 however the data has now started to rise again.



In line with national drivers the Trust is focusing on learning from deaths through its mortality review process and relying less on these complex statistical measures.

Although the original aim has not been achieved the key work plan that will lead to improvement namely the Care of the Acutely Ill Patient programme is continuing. The programme tracks progress in each of the 8 themes with clear targets and areas of work. Progress is overseen by the Clinical Outcomes Group on a monthly basis reporting through the Trust's Quality Committee to the Board of Directors. The programme is scheduled to continue in its current form to September 15 and will then be reviewed again against its outcome aims.

Specifically two of the priorities for this year – sepsis and administration of IV antibiotics will have a positive impact on this outcome.

Priority two: To ensure intravenous antibiotics (IV) are given correctly and on time

When infections are diagnosed it is essential antibiotics are given correctly and on time to aid recovery and ensure that the patient's condition does not deteriorate.

Although work has continued and improvements made the Trust did not meet the initial aims for improvement in this area, it has been agreed that this priority will continue in the Quality Account for the next year. Work will be linked to the interventions needed to meet the national sepsis commissioning for quality and innovation (CQUIN) target.

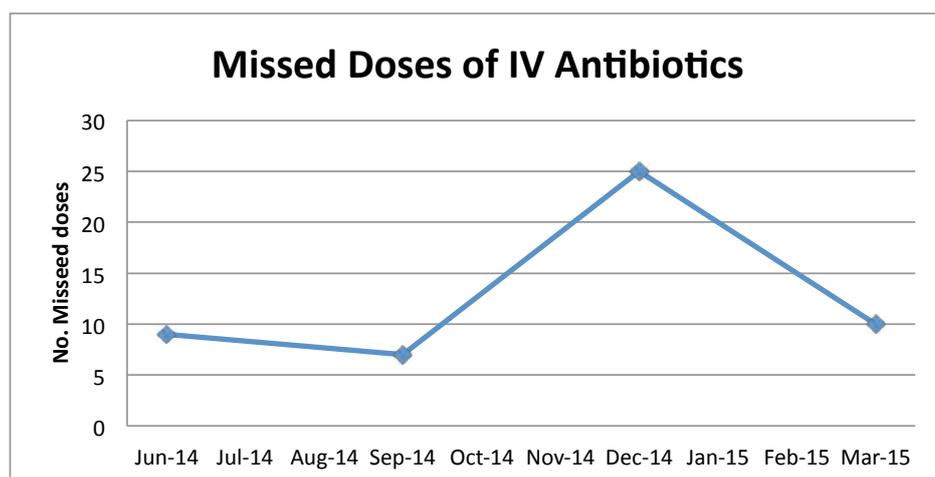
a. Target

- The Trust aimed to reduce by 50% unintentional missed doses of IV antibiotics.
- To ensure that antibiotics are prescribed according to Trust guidelines.

b. Achieved year to date

Measurement of this priority remained a challenge; data is currently gathered through focused audit carried out by the specialist pharmacy team and also the quarterly point prevalence audit focussing on missed doses

Data from the trust-wide quarterly missed doses audit contains specific questions around IV antibiotics.



The specialist antibiotic pharmacy team undertake a six monthly antibiotic audit measuring if antibiotics are given according to Trust guidelines. Results of the latest audit conducted in November 2014 (split by the two main hospital sites) were as follows:

Calderdale Royal Hospital - 100% compliance all wards apart from one surgical ward at 70%.

Huddersfield Royal Infirmary - 100% on Medical and Rehabilitation wards. Surgical wards overall had 91.4% compliance.

It is worth noting that a figure of 100% compliance was achieved for the prescribing of antibiotics according to Trust guidelines.

Because of the way administration of antibiotics is recorded on the prescription chart it is difficult to calculate if the IV antibiotic was given within the accepted 1 hour time period. In addition there is a lot more understanding of the reasons why doses are missed and delayed. This has led to a detailed action plan. Unfortunately as these are large scale actions they need to be fully implemented before the impact is seen.

Antibiotic ward rounds have continued on a twice weekly basis. This is a ward round involving a consultant Microbiologist, specialist antibiotic pharmacist and infection control nurse. The focus of these is education, challenge, advice and monitoring of antibiotic use. These ward rounds have also helped the specialist staff gain further understanding of the issues in administering and prescribing antibiotics in clinical areas.

The specialist pharmacists continued to work with junior front line staff in implementing changes in their ward/departmental areas.

One key piece of work being carried forward was the identification of the time taken to reconstitute and administer Piperacillin-tazobactam (one of the Trust's most widely used antibiotics) leading to a trial of a "docked-vial" version of this antibiotic commencing after Easter 2015 at HRI.

Priority three: Improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital

At any one time 20% of all adult patients in hospital have diabetes. Patients with diabetes stay on average two days longer than patients without diabetes. The Trust wants to improve the care of patients with diabetes and encourage more patients to manage their own diabetes whilst on the ward. Often patients with diabetes are experts in their condition, therefore encouraging them to continue to manage their diabetes whilst in hospital reduces error, maintains independence and shortens length of stay.

a. Improvement work carried out

The focus of this work was around supporting patients to self-care with their medications, which included patients with diabetes who self-administer their insulin.

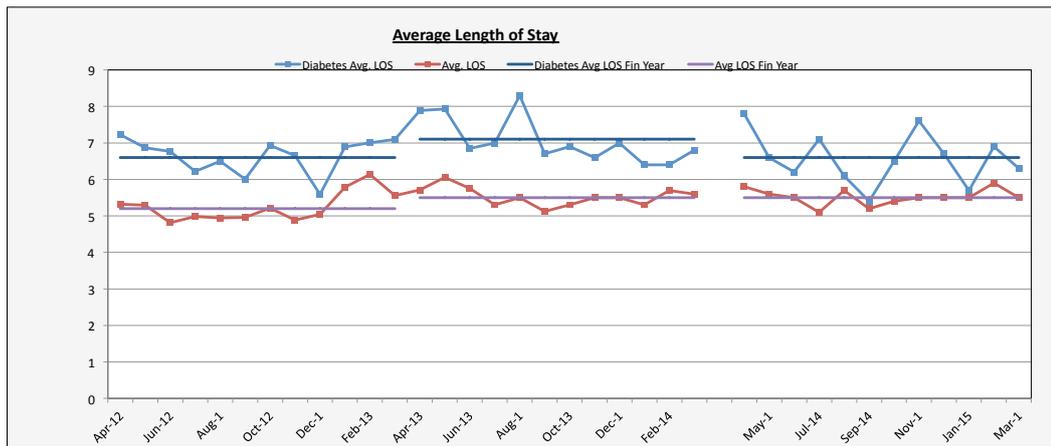
This was achieved through the introducing of a process for medication self-administration, robust testing of this process had already taken place.

This improvement work meant that more patients (if they are assessed as able), were encouraged to test their own blood sugars, adjust the dose, administer their own insulin, and had full access to snacks should they need them to manage their blood sugars. Over the year further wards were included in the work (a maternity and a short stay ward) making a total of eight wards using the new process.

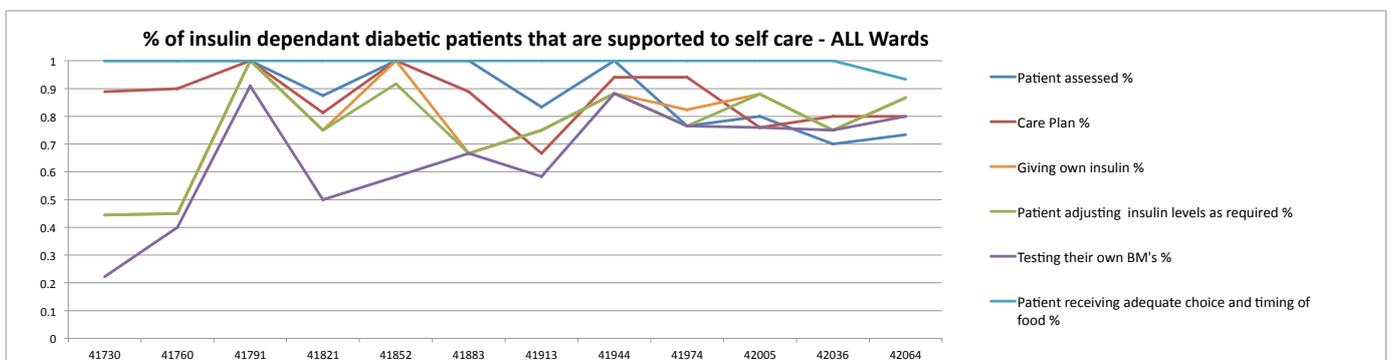
b. Target

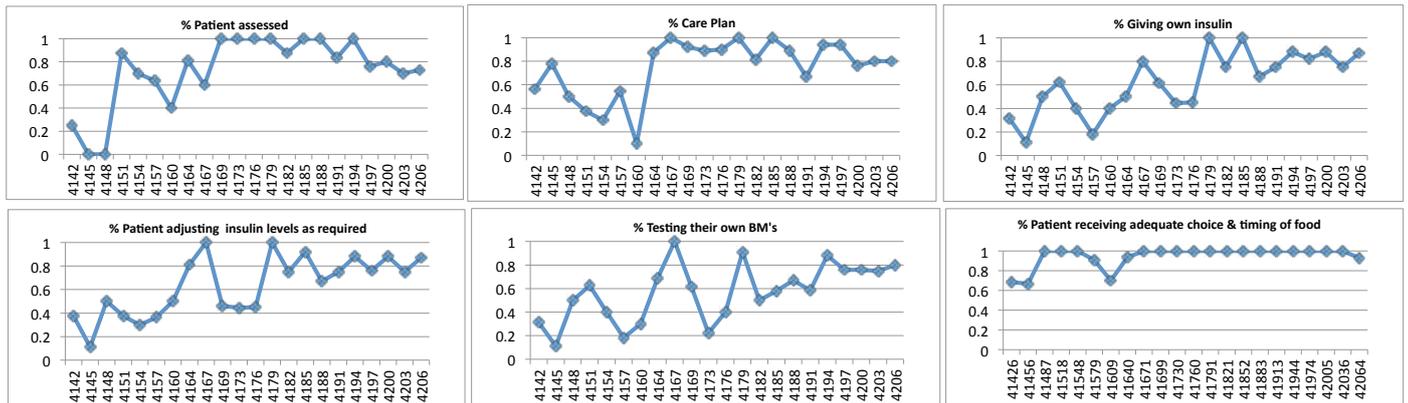
The overall outcome and aim of the work was to reduce harm and length of stay for diabetic patients through encouragement to self-manage.

The chart below shows an improvement in length of stay for patients with Diabetes from May 14 that has been sustained throughout the year.



The following charts show overall compliance and improvement with using the care bundle for patients self-administering their Insulin. It also includes compliance with each of the 6 individual elements.





c. Further work

A further two wards (an Orthopaedic ward and an Oncology ward) will be included during the next quarter; training is underway on these wards. The CQUIN requirements for 2015-16 means that a further two wards will be included in this work each quarter.

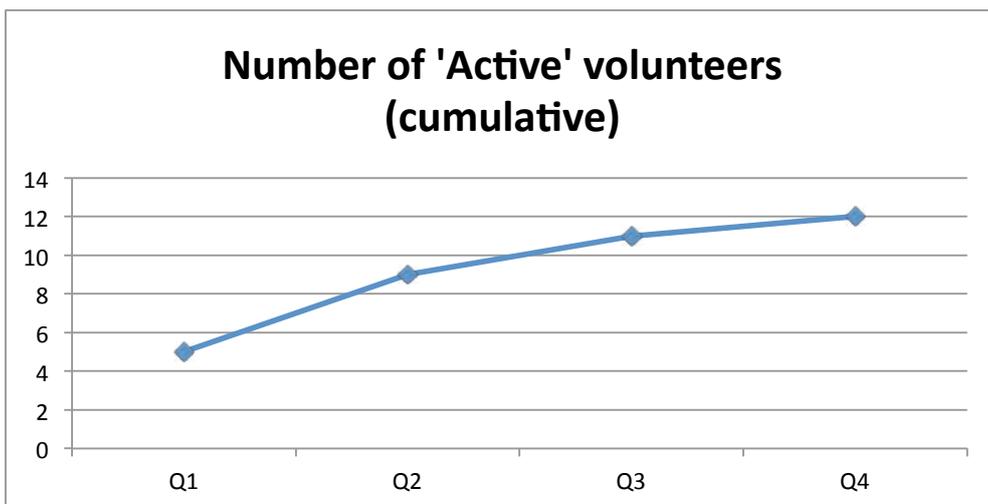
To support the work a campaign is to be held in June 2015 to encourage patients to bring their own medication into hospital and self-medicate, this will include diabetic patients.

Priority four: To help patients with long term pain develop the skills needed to manage their conditions through supported self-management courses

This course is one part of an overall programme that aims to further embed self-management into the care given to patients. By developing self-management skills, patients become more confident to manage their condition better and to work in a more collaborative way with health professionals. The outcome is more activated patients who want to maintain more control of the management of their lives and their health.

a. Improvement work carried out

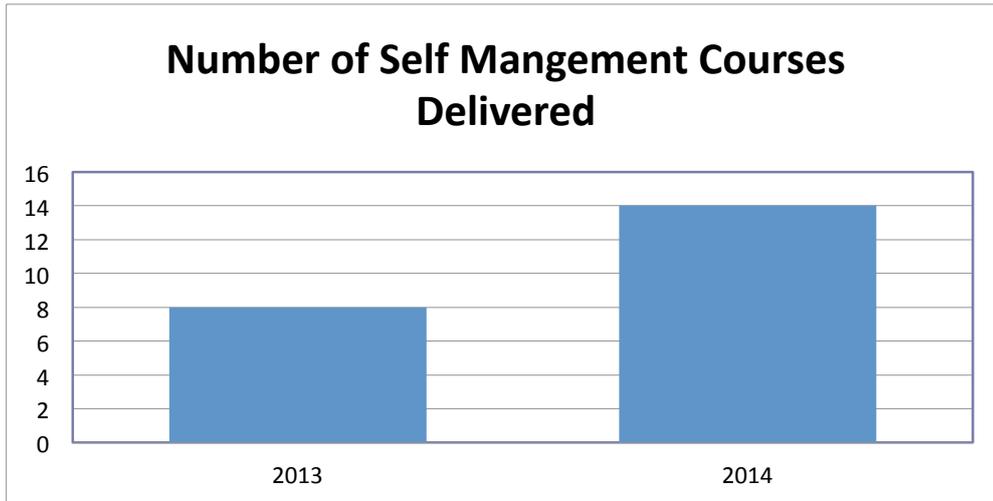
So far this year 12 new tutors have been trained – this includes 7 staff and 5 volunteers. The Trust is in the process of recruiting further volunteers following keen interest from course participants. There are now 12 active volunteers delivering this programme.



14 programmes were delivered in 2014 and new patient information leaflets were launched in June 2014. Demand for courses has increased, with more calls to the programme office received since the new leaflets were used. The first course ever has now been delivered in Todmorden with 15 people completing the course.

The number of courses being provided has increased and there is no waiting list currently. Due to work carried out by community rehabilitation teams there was a further train the trainer course in 2014. This focussed on training clinical tutors so that courses can be carried out for new groups of patients.

All the volunteers have now delivered a course to patients. They have been supported by experienced volunteers who helped build their confidence.



From simple feedback measures post course all responses for this year to date have been in the positive range. Mean confidence scores changed from 3.5/10 at the beginning of the course to over 8/10 at the end of the courses from a cohort of 40 participants.

Participants reported numerous achievements against the goals they set on courses stating they felt more in control. Participant feedback about tutors has been complimentary and indicates how valued the input of our volunteers is alongside clinical tutors.

The volunteers won the CHFT Volunteer of the Year award at this year's Celebrating Success Awards. They are very grateful and proud of this recognition. The work they do is invaluable in supporting other people with long term conditions.



b. Target

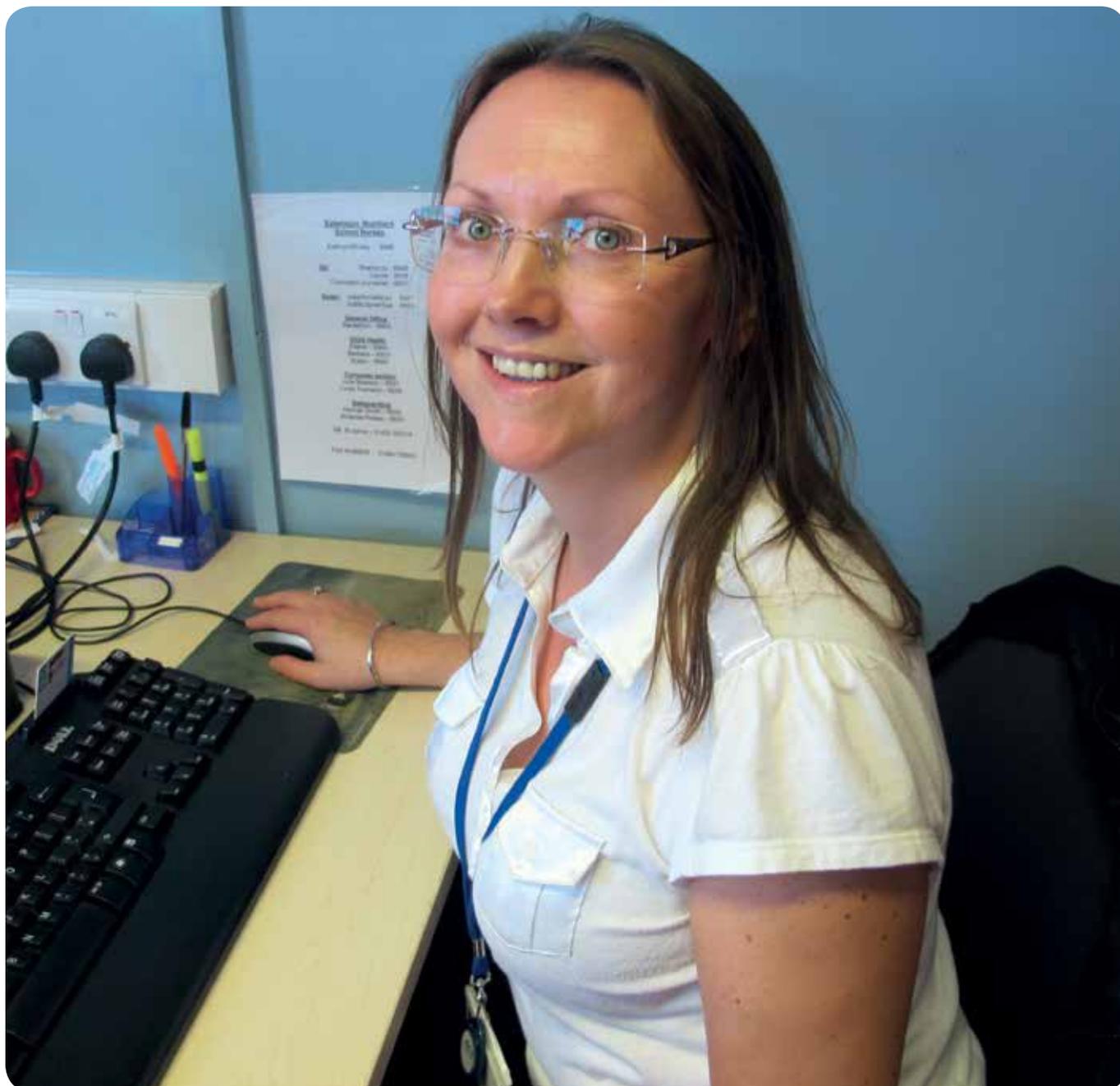
- Continue to deliver supported self-management courses and improve the quality of these courses and patient number attending.
- Improve the quality and usefulness of materials provided to patients.
- Continue to utilise the experience of the advocates for self-management (patients who have attended the course before).
- Increase the mean improvement score in the confidence of attendees to 'take control' of their conditions. A range of measures were used to ascertain if the courses have linked to improved outcomes.

c. Further work

Work has progressed on a new participant handbook to complement the self-management programme. This is currently being drafted and will be tested on a course before being signed off for printing.

Courses for people with Multiple Sclerosis and Parkinson's disease are being developed to start in April 2015 and work is on-going to integrate the approach into the existing falls prevention programme.

From the organising of the Todmorden course the team have learnt that working closely with the GP practice to recruit participants was helpful – this is a more proactive way of working than waiting for participants to apply themselves. The idea is to try this approach against when recruiting for the 16 courses planned for next year.



Looking ahead to 2015/16

A 'long list' of potential priorities for 2015/16 was developed from the following sources:

- regulator reports,
- incidents and complaints,
- on-going internal quality improvement priorities,
- national reports and areas of concern,
- evaluating the Trust's performance against its priorities for 2014/15,
- at a membership council workshop meeting.

This long list was discussed with the Trust's Membership Council; an opportunity to vote was also given via the Trust's internet site, advertised in the local press and through a tear off slip in Foundation News sent out by post to all Trust members.

This work has helped identify the following quality improvement priorities for 2015/16 because they are important to the Trust's stakeholders.

One priority has been carried over into this year's account as this was only partially achieved. It was agreed that three new projects should be selected this year that better reflected the current quality priorities for the Trust.

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

The four priorities for 2015/16 are:

Domain	Priority
Safety	Improving Sepsis Care
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time (continued from last year)
Effectiveness	Improving the discharge process
Experience	Better Food

Priority One - Improving Sepsis Care

Why we chose this

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

Sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 37,000 deaths attributed to sepsis annually. Of these some estimates suggest 12,500 could have been preventable. Problems in achieving consistent recognition and rapid treatment of sepsis are currently thought to contribute to the number of preventable deaths.

The Trust has been actively working to reduce mortality and harm from sepsis for three years, significant improvements have been made around mortality rates but it is recognised that more can be done specifically around reliable screening for sepsis and making sure IV antibiotics are given within the one hour recommended timescale.

Improvement work

- Introduce reliable screening for sepsis for patients presenting in A&E's and other direct admission areas.
- Ensure when identified with severe sepsis, red flag sepsis or septic shock patients get the initial IV antibiotic dose within one hour.

Target

To achieve significant improvement in both of the above focussed areas for improvement by March 2016. We will measure our baseline performance in quarter one of the year and set a target for improvement based upon that measurement.

Reporting

The progress of improvement work around sepsis is monitored by the deteriorating patient collaborative (part of the care of the acutely ill patient programme), overseen by the Clinical Outcomes Group, Quality Committee and by exception Trust Board. In addition there will also be monthly reporting as part of CQUIN's requirement into the Trust Integrated Board Report.

Priority 2 - to ensure Intravenous (IV) antibiotics are given correctly and on time

Why we chose this

When infections are diagnosed it is essential antibiotics are given correctly and on time to aid recovery and ensure that the patient's condition does not deteriorate.

Work has been on-going in the Trust for a number of years and changes have occurred but this priority was chosen as it is recognised that further improvements need to be made.

Improvement work

The focus of the improvement work this year will continue to be around ensuring the Trust is ready for the new electronic prescribing system.

On-going audit work will continue so improvements can be targeted where they are most needed, point prevalence audits of antibiotic use in the Trust will happen quarterly through 2015-16 as part of the missed doses work. In addition the Trust's specialist antibiotic pharmacists will continue to audit trust wide every six months that antibiotics are given according to Trust policy. Results will be directly fed back to wards that are non-compliant.

Antibiotic ward rounds will continue on a twice weekly basis. The focus of these is education, challenge, advice and monitoring of antibiotic use. Different themes as they emerge will be targeted for improvement, for example the Trust is currently looking at intravenous Meropenem use.

The specialist antibiotic pharmacists will continue to work with junior front line staff in implementing change in their own ward/departmental areas, a number of junior doctors are currently working on their ideas for improvement.

The Trust has identified that the time taken to reconstitute and administer Piperacillin-tazobactam (one of the most widely used antibiotics) is significant – a trial of a "docked-vial" version of this antibiotic begins after Easter 2015 at HRI which will make the process quicker and simpler.

Target

- The Trust aim is to reduce by 50% unintentional missed doses of IV antibiotics.
- To ensure that antibiotics are prescribed according to Trust Guidelines.

Reporting

Reporting of progress is through missed doses audits via the Medication Safety Group, reporting in to Patient Safety Group and by exception to quality committee and Trust Board. In addition this measure is linked to the Sepsis CQUIN (IV Antibiotics) so will also report in via this route.

Priority 3 - Improving the discharge process

Why we chose this

We aim to make leaving the Trust and returning home for continuing recovery as smooth as possible by working closely within the Trust and with partner organisations.

Improvement work

The Trust will do this using a number of key improvement ideas.

One area the Trust is keen to target is to make sure patients are kept better informed around their discharge planning. On admission to hospital the clinical team decide on an estimated date of discharge when the patients care and treatment will have been completed. The Trust acknowledges that this has not always been consistently communicated. The idea is to use a welcome letter for all patients when they are admitted, this letter will contain discharge information around the process, an initial expected date of discharge so plans can be made and if concerns are raised who to talk to.

To supplement this the 'ticket home' conveys discharge information at the bedside to ensure family and carers are sufficiently informed of plans and ways in which they can support a smooth discharge.

It has also been acknowledged that staff have not always been proactive in discharge planning leading to patients staying in hospital longer than necessary, increasing their risks and potentially delaying full recovery. To address this a training programme for staff is being developed.

Closer ties are being forged with our local authority partners and other care providers to better understand and tackle the causes of delay for example equipment and transport issues. The aim is to ensure better cooperation around discharges to enable better planning and greater efficiency.

Target

A reduction in the number of patients who are delayed in leaving hospital when active treatment has ended.

To ensure patients are not being discharged too early the Trust tracks readmission rates; the aim is to stay below the national average rate of 7.30%.

Improvement in patient involvement in discharge planning scores (from patient surveys).

Reporting

The overall responsibility for efficiency of bed use (encompassing timely and appropriate bed use) reports into the bed efficiency group, reporting to the Executive Director of Nursing and Operations and through this to Executive Board and Board of Directors.

Priority 4 - Better Food**Why we chose this**

The Trust has a responsibility to provide the highest level of care possible and this includes the quality of the food that is provided for patients.

Nutrition designed to meet patients' individual needs is central to a good recovery. The Trust aims to provide patient choice which is both hot and appetising and nutritionally balanced.

Improvement work

Good nutrition has been a priority for the Trust for the past few years, through the past year working nationally with the 'food for life' initiative along with two other Trusts. This project has received funding for another two years from Calderdale Clinical Commissioning Group (CCG). As an organisation 'food for life' are known for their certificate scheme, the Catering Mark, which supports organisations to meet sustainability and nutrition standards in catering. Through the Big Lottery Fund the work is focussing on developing a new health promoting hospital model that focuses on food.

There has been a local CQUIN in place for the past year supported by local Healthwatch, Calderdale Care CCG and both council's public health teams focussing on improvements to the quality of the food being provided. Some changes resulting from the work have included bespoke menus for paediatrics and the introduction of homemade soups. A key part of the success of this work has resulted from improved partnership working between nursing, dietetics and catering in the Trust.

The CQUIN for next year will continue to focus on further improving the quality of food. In addition the work commenced as part of the 'food for life' initiative will continue to be developed and changes made. The continued engagement of key staff members will enable further sustained improvements.

Another piece of work is around vending machine food choices, the aim is to improve patient, visitor and staff choice whilst providing healthier options.

Target

The targets for this work will be in line with CQUIN requirements measured by:

- Improvements in the percentage of patient satisfaction with the quality of food provided.
- Reduction in food waste
- Changes that make the choices in vending machine healthier

Reporting

There will be quarterly reporting of progress against the CQUIN targets.

Operationally there is a multi-agency food steering group in place that reports to the Patient Experience Group and to the Trust's Quality Committee.



Award-winning: Acre Mills



Statements of assurance from the Board

Review of services

During 2014/15 the Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 41 relevant health services.

The Calderdale and Huddersfield NHS Foundation Trust has reviewed all the data available to it on the quality of care in 34 of these relevant health services.

The income generated by the relevant health services reviewed in 2014/15 represents 62.55% of the total income generated from the provision of relevant health services by the Calderdale and Huddersfield NHS Foundation Trust for 2014/15.

Participation in Clinical Audits

During 2013/14, 32 of the national clinical audits and four national confidential enquiries covered relevant NHS services that the Calderdale and Huddersfield NHS Foundation Trust provide.

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

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust was eligible to participate in during 2014/15 are contained in Appendix A

Participation in clinical research

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2014/15 that were recruited into trials during that period to participate in research approved by a research ethics committee was 1, 056.

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

The Trust was involved in conducting 154 clinical research studies of which 55 were actively recruiting, 87 were closed to recruitment (but participants were still involved) and 13 studies were 'in set up' (either waiting for initiation or local approval).

During 2014/15 actively recruiting research studies were being conducted across four of the five divisions in fourteen specialties:

- Women, Children and Family Services (5 studies, 3 specialties);
- Diagnostic and Therapeutic Services (5 infection studies);
- Medical Services (42 studies, 9 specialties);
- Surgical and Anaesthetic Services (3 ophthalmology studies).

There were 67 clinical staff participating in research approved by a research ethics committee at the Trust during 2014/15, of which 54 were local principal investigators and one was chief investigator on an international multicentre clinical trial. There was one clinician commencing, and a further 5 continuing their studies at doctoral level.

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

Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2014/15 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The figure for CQUINs allocated for 2014/15 was £6.8 million and for 2015/16 is £6.7 million. The Trust did not achieve the target for the Asthma CQUIN 2014/15 CQUIN programme. However, the 2014/15 CCG contract was under a fixed value agreement, inclusive of CQUINs, so no loss of CQUIN funding was incurred due to the failure of this target.

The CQUIN areas identified for 2014/15 covered a broad range of areas and reflected priorities specified at a national level supported by local priorities identified in partnership between commissioners and the Trust.

Four National CQUIN areas were identified for 2014/15:

- Friends and family test
- NHS Safety Thermometer Harm Measurement Indicator
- NHS Safety Thermometer - Reduction in the prevalence of pressure ulcers
- Dementia screening and referral; Clinical leadership and carer support

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

- Respiratory care bundles – asthma and community acquired pneumonia
- Diabetes: supporting the treatment of patients presenting acutely with hypoglycaemia and the promotion of self-care
- Improving medicines safety (transfer of care and discharge accuracy checks)
- End of life care
- Improving hospital food

In planning for 2015/16 the Trust has continued to work closely with local commissioners to develop a programme of CQUIN quality indicators which are consistent with the key challenges faced locally. The development of these areas of focus has had strong clinical involvement in identifying areas for possible inclusion.

A number of 2014/15 CQUIN indicators have been retained and will enter a further year of targeted improvement work during 2015/16:

Four national CQUIN areas were identified for 2015/16:

- Acute Kidney Injury
- Sepsis – screening and antibiotic administration
- Urgent care
- Dementia screening and referral; Clinical leadership and carer support

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

- Respiratory care bundles – asthma and community acquired pneumonia
- Diabetes – promotion of self-care
- Improving medicines safety (transfer of care and discharge accuracy checks)
- End of life care
- Hospital food – patient satisfaction, reduction of waste and vending

Further details of the nationally agreed goals for 2014-15 and for the following 12 month period are available electronically at: <http://www.england.nhs.uk/nhs-standard-contract/>

Care Quality Commission registration

The Trust is required to register with the Care Quality Commission (CQC) and has full registration without conditions. The CQC has not taken enforcement action the Trust during 2014/15.

The Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Intelligent Monitoring Report

To date in 2014-15 two reports have been published for the Trust.

Each report contains a priority band for inspection of the Trust, 1 being the highest priority for inspection (i.e. where the data indicates greatest concern for care quality) and 6 being the lowest priority.

The indicators cover:

- Incidents
- Infections
- Mortality
- Maternity and women's health
- Readmissions
- Patient Reported Outcome Measures (PROMs)
- Audit
- Compassionate care
- Meeting physical needs
- Overall experience
- Treatment with dignity and respect
- Trusting relationships
- Maternity survey
- Access to treatment measures
- Discharge and integration
- Patient-led assessments of the care environment
- Reporting culture
- Partners
- Staff survey
- Staffing levels
- Qualitative intelligence

In the July 2014 report the Trust was banded as a 4. The reasons for this rating are graded as elevated risks and risks.

Elevated risks were reported for the following:

- The proportion of patients assessed as achieving compliance with all 9 standards of care as measured through the hip fracture database (April 12 to March 13).

Risks were reported for the following:

- Composite of Central Alerting System (CAS) indicators (Feb 13 to Jan 14)
- Sentinel stroke national audit programme (SSNAP) – overall team-centred rating score for key stroke indicator) Oct 13 to Dec 13).
- Maternity survey – 'did staff treating and examining you introduce themselves' (Feb 14)
- Monitor – continuity of service rating (May 14)
- Electronic Staff Record items relating to staff support/supervision (March 14).

In the October 2014 report the Trust was banded as a five (an improvement of one band from July 14). Elevated risks were reported for the following:

- The proportion of patients assessed as achieving compliance with all nine standards of care as measured through the hip fracture database (Oct 13 to March 14).
- Consistency of reporting to the National Reporting and Learning System (NRLS) (Oct 13 to Mar 14).

Risks were reported for the following:

- SSNAP – overall team-centred rating score for key stroke indicator (Oct 13 to Dec 13).
- Composite risk rating of ESR items relating to staff support/supervision (Aug 13 – July 14).

It is of concern that standards of care as measured through the hip fracture database have remained an elevated risk through this year – this encompasses data between April 12 to March 14.

There is a detailed action plan in place in the surgical division to address this. Over the year so far the Trust has seen improvement and delivered all nine elements to over 30% of patients (based on a trajectory where the Trust was below 30% at the beginning of the year).

In the five months from November 2014, 77% of patients had their operation within 36 hours.

The trauma co-ordinator has taken responsibility for addressing the gaps in the national hip fracture database that were due to administration or task management.

A key challenge is to fill medical posts; the Trust continues to advertise but has had little success to date. In the meantime to address any risk some of the junior doctor vacancies are covered by locums.

The elevated risk around the NRLS had already been noted by the risk team at the Trust, due to staff changes some inconsistencies had developed. These have now been corrected and a system of a weekly upload put into place and is being performance managed. This new system has been discussed with the Trust's CQC compliance inspector who is satisfied with the changes.

The Trust is aware of on-going risk around the SSNAP – (overall team-centred rating score for key stroke indicator Oct 13 to Dec 13). There is a detailed action plan in place and being delivered around Stroke Care (see local indicator for more detail). Composite risk rating of electronic staff record (ESR) items relating to staff support/supervision (Aug 13 – July 14). This risk specifically relates to the ratio of band 7 nurses to band 5/6 nurses and proportion of all ward staff who are registered nurses. This data set has now been added to the well led domain dashboard using the same calculations as the CQC so it can be monitored internally. There has been some improvement in both data sets; however both indicators are still below the expected rate. In addition through the 'Hard Truths' work safe staffing levels are being monitored monthly. Band 7 nurses are also being introduced in the Trust's community team which will improve ratios. Band 8A nurses are supervising and supporting band 5 and 6 nurses.

Data quality

The Trust has signed a contract with 'Cerner' for the implementation of their Millennium electronic patient record (EPR) system during 2016. This not only provides an opportunity to modernise the Trust's operating procedures to support and improve patient care, but also acts as a driver to improve data quality. During the next 18 months, the Trust will:

- Agree an approach to data migration from legacy systems
- Undertake cleaning of the data to be migrated
- Develop operating procedures for data collection within the EPR
- Work with the EPR business change and training teams to incorporate data quality awareness
- Identify future integration solutions between the EPR and bespoke systems, including the tactical deployments for theatres, vital signs, scanned case notes and maternity deployed in 2014/15 and early 2015/16

As the current PAS system now has a limited lifespan, data quality management will focus on continuing to address data quality issues identified through audit or through operational experience and addressing any new data quality standards mandated nationally or through commissioning requirements.

NHS Number and general medical practice code validity

The Trust submitted records during 2014/15 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was:
 - Admitted Patient Care = 99.8%
 - Outpatient care = 99.9%
 - Accident & Emergency Care = 98.8%
- Which included the patient's valid General Practitioner's Registration Code was:
 - Admitted Patient Care = 100%
 - Outpatient Care = 100%
 - Accident & Emergency Care = 99.9%

These figures are based on April 2014 to January 2015, which are the most recent figures in the Data Quality Dashboard.

Information Governance

The Trust Information Governance Assessment Report overall score in March 2015 is 78% and graded as 'satisfactory' with all scores at a level two or three.

In the submission of the information governance toolkit for March 2015 the Trust scored 78% and was marked as 'satisfactory'. All scores were either at a level two or a level three. A substantial programme of work is under way for 2015/16 to promote the continued use of technology within the Trust this includes the electronic patient record. There will be leaflets, awareness raising events and visits to wards and departments across the Trust to interact with staff and ensure that all information governance standards are being adhered to.

Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit 2014/15 by the Audit Commission.

Review of quality performance – how we compare with others

In this section you will find more information about the quality of services that the Trust provides by looking at performance over the last year and how the Trust compares with other Trusts.

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

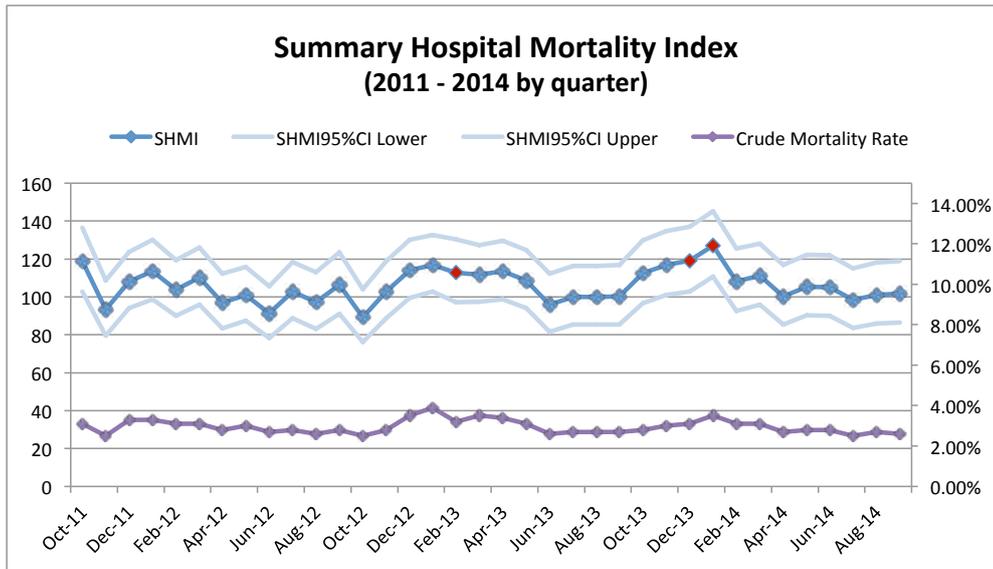
Summary table of performance against mandatory indicators

Indicators	Previous 2 Periods		Most Recent Period
	Jul 2011 – Jun 2012	Jul 2012 – Jun 2013	Oct 2013 – Sept 2014
12. Summary Hospital-Level Mortality Indicator (SHMI).	Jul 2011 – Jun 2012	Jul 2012 – Jun 2013	Oct 2013 – Sept 2014
(i) the value and banding of the summary hospital-level mortality indicator (“SHMI”) for the Trust for the reporting period: National Average: 100 Lowest: 54.1 Highest: 119.8	102	105.7	109
(ii) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National Average: 24.6 Lowest: 0 Highest: 49	19.1%	19.7%	20.3%
18. PROMS; patient reported outcome measures.	2011/12	2012/13	2013/14
(i) groin hernia surgery,*	0.10	0.07	0.07
(ii) varicose vein surgery,*	0.09	0.10	0.11
(iii) hip replacement surgery, and *	0.45	0.43	0.44
(iv) knee replacement surgery.*	0.32	0.37	0.34
19. Patients readmitted to a hospital within 28 days of being discharged.	2012/13	2013/14	2014/15
(i) 0 to 15; and	8.9 %	8.7 %	9.0 %
(ii) 16 or over.	7.3 %	6.8 %	6.5 %
20. Responsiveness to the personal needs of patients. (this data is yet to be released for 2014)	2012	2013	2014
	69%	68%	TBC
21. Staff who would recommend the Trust to their family or friends.	2012	2013	2014
	69%	68%	65%
New Indicator - Patients who would recommend the Trust to family or friends.	Jan 2015	Feb 2015	Mar 2015
	96.5	95.6	96.4
23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	2014/15 Q1	2014/15 Q2	2014/15 Q3
	95.3%	95.4%	95.3%
24. Rate of C.difficile per 100 000 bed days	2012/13	2013/14	2014/15
	14.3	12.0	6.2
25. Patient safety incidents and the percentage that resulted in severe harm or death.	April 13 - Sept 13	Oct 13 - March 14	April 14 - Sept 14
(i) Rate of Patient Safety incidents per 1000 Bed Days	5.51 (per 100 Admissions)	5.24 (per 100 Admissions)	36.22
(ii) % of Above Patient Safety Incidents = Severe/Death	2.6%	1.3%	1.2%

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

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

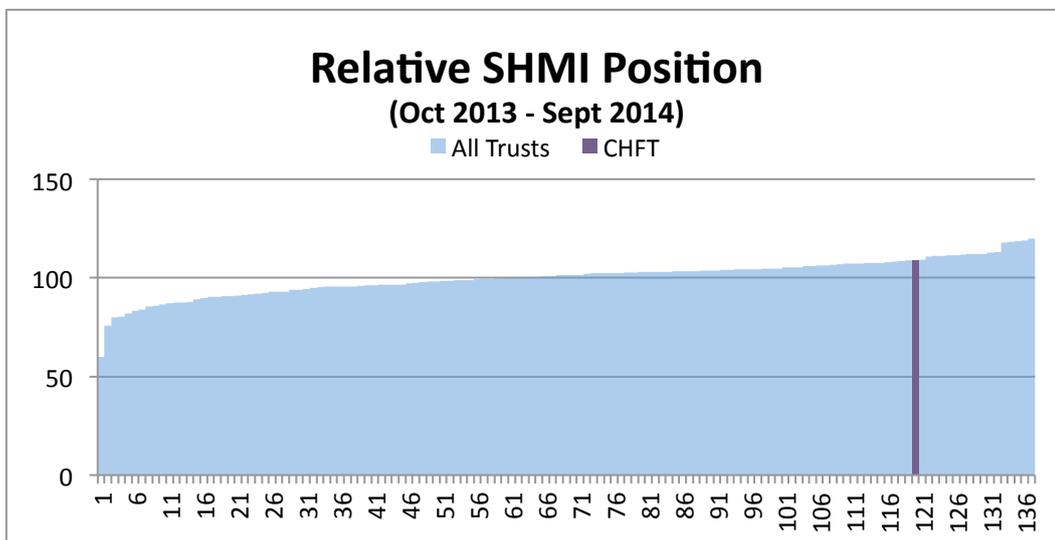
The chart below shows the value and banding of the SHMI for the Trust for the reporting period from October 2011 to September 2014.



100 is the expected score based on data submitted from all NHS trusts.

The blue diamond's represent the Trust's position for the quarter. Where the diamonds are red this means the quarter they represent had a statistically significant relative risk (i.e. the lower 95% confidence limit and the upper 95% confidence limit are both above 100) that was higher than predicted.

This chart shows the Trust's relative positions when compared against other acute NHS providers in England.



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

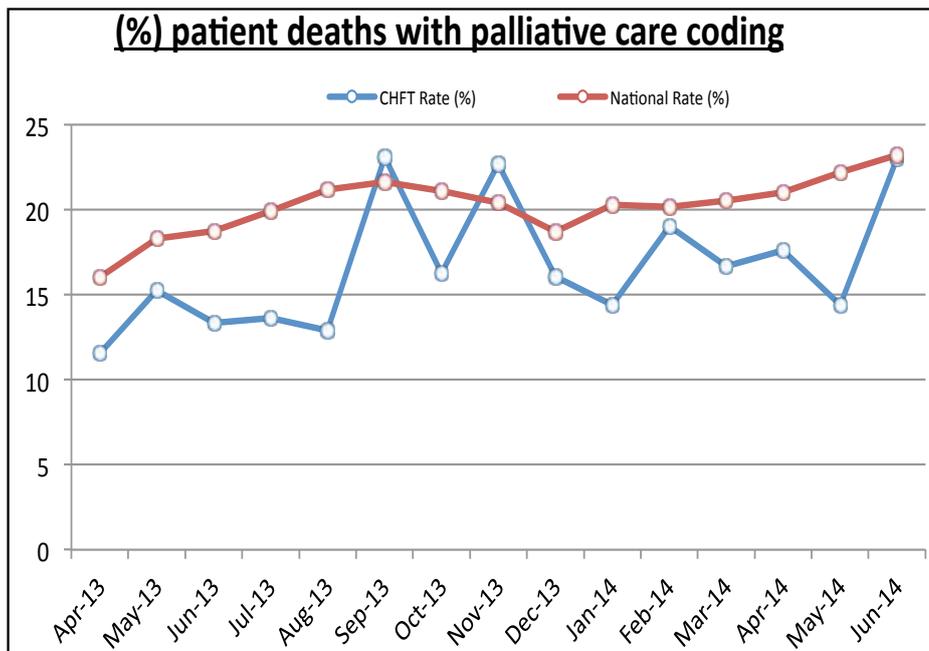
- The SHMI data shows the Trust's performance against the expected mortality rate of 100. Data available for the past three years is relatively stable against expected with two periods (red diamonds) of concern.

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

- The impact on SHMI is linked to the Trust's strategy for improving the quality of care overall. The largest programme designed to impact on SHMI is the care of the acutely ill patient programme. This has been running since October 2013; reviewed in October 2014.
- In addition the SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected, where this occurs cases are investigated and reports presented to clinical outcomes group with actions where necessary.

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

The chart shows the percentage of Calderdale and Huddersfield NHS Foundation Trust hospital deaths that have a palliative care code against the national rate.



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

- The Trust data has been variable when compared to the national rate however the latest data point available shows it to be the same illustrating an improvement.

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

- Use of palliative care coding is monitored closely, it is reported monthly in the coding dashboard which is discussed at divisional and Trust level, and any issues with performance are identified and discussed. The coding team have carried out work to ensure the national rules are being correctly applied to the Trust's data.

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

Patient reported Outcome Measures (PROMS) are a way of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

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

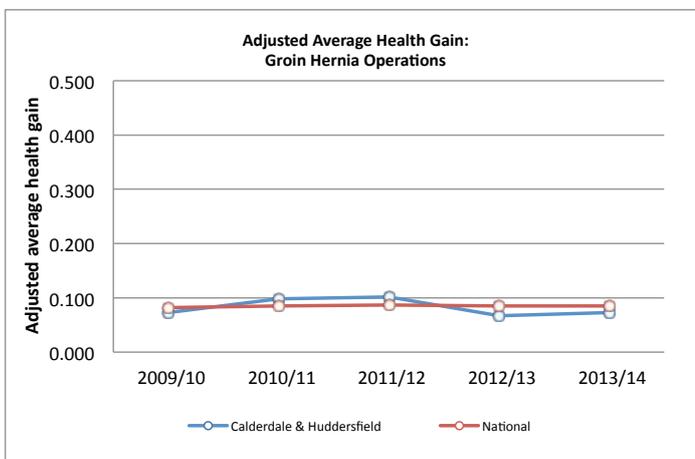
- Groin Hernia;
- Hip replacements;
- Knee replacements;
- Varicose Veins.

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

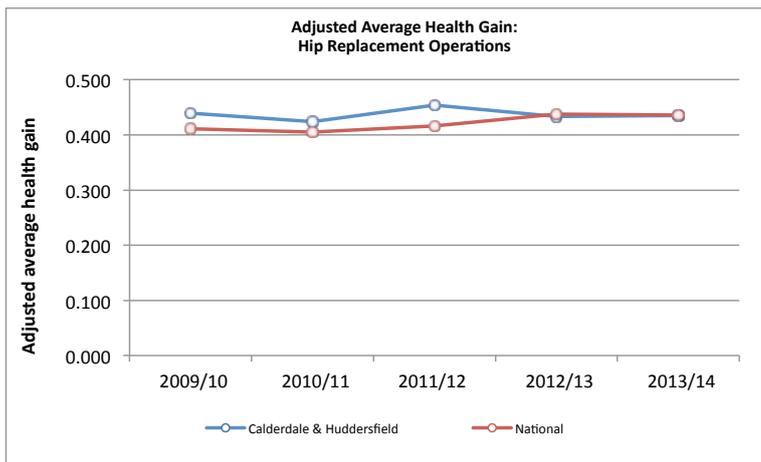
Please note: there is no data available showing the Trust compared to best and worst performers

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

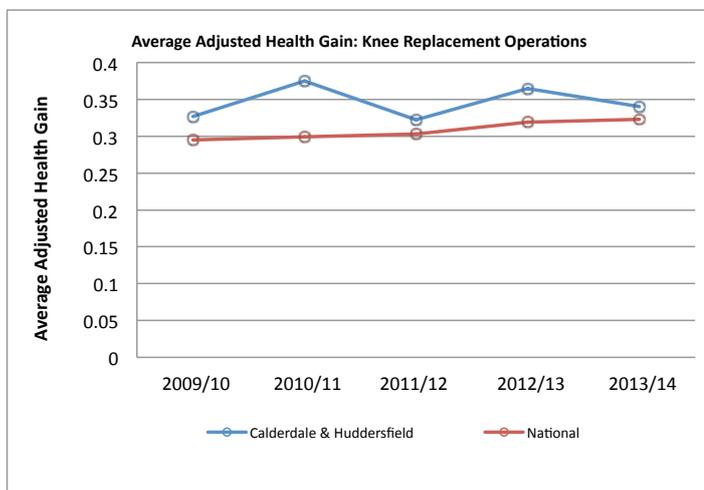
- Participation: Nationally there were 251,843 eligible hospital episodes and 194,643 pre-operative questionnaires returned – this equates to a headline participation rate of 77.3% across all 4 procedures, for CHFT the rate was 77.7% (slightly above). For the post procedure questionnaires the national response rate was 67.8%, for CHFT it was 72.1% (significantly better).
- Health Gain compared to national data: Note the graphs show the increase or decrease in health gain each year, the data below is the percentage of patients reporting a health gain in 2013/14 (the latest data available).



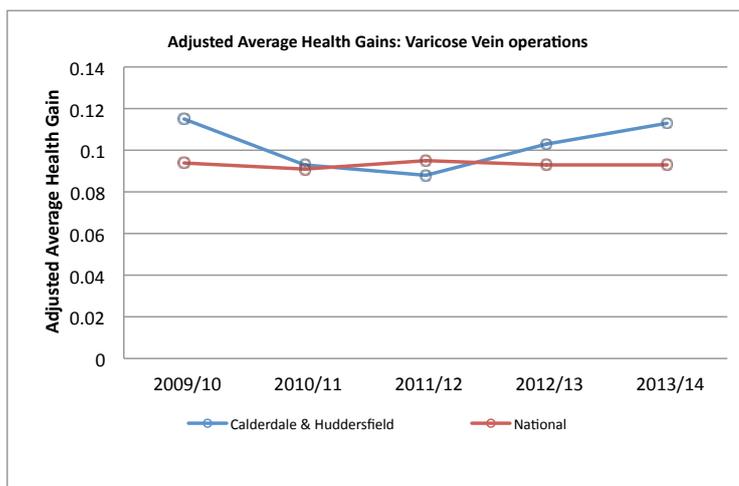
Groin Hernia – Calderdale and Huddersfield NHS Foundation Trust, 46.1% have improved, England 50.6%. This data is taken from 152 responses.



Hip Replacement – Calderdale and Huddersfield NHS Foundation Trust, 90.2% have improved, England 89.3%. This data is taken from 255 responses.



Knee Replacement – Calderdale and Huddersfield NHS Foundation Trust, 82.4% have improved, England 81.4%. This data is taken from 295 responses.

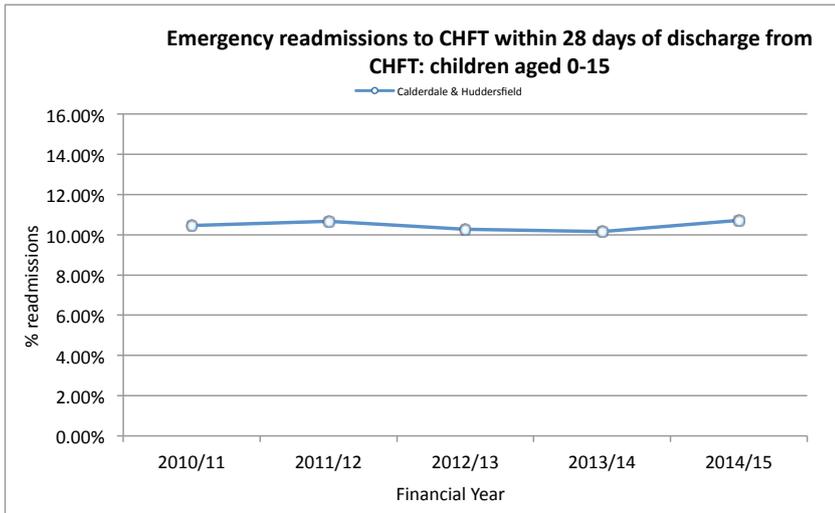


Varicose Veins – Calderdale and Huddersfield NHS Foundation Trust, 51.7% improved, England 51.8%. This data is taken from 87 responses.

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

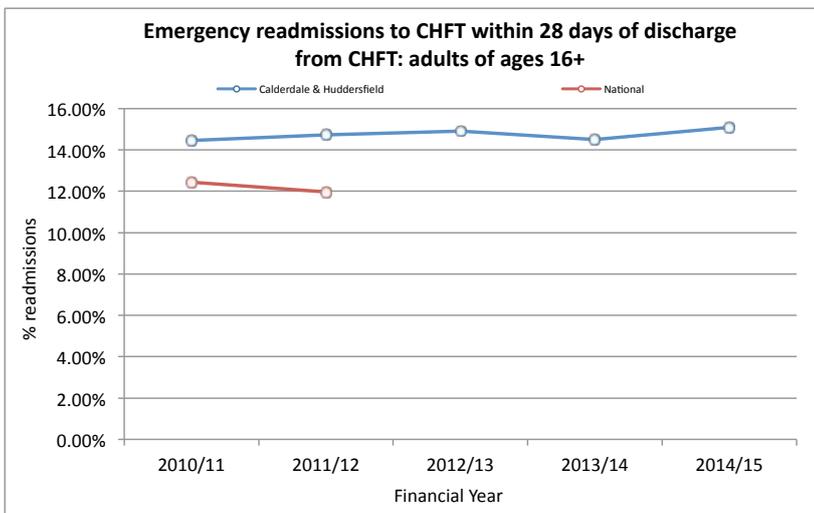
The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this score and so the quality of its services, by:

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



0-15	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	10.45%	10.66%	10.27%	10.16%	10.72%

Age 16 and over



16+	2010/11	2011/12	2012/13	2013/14	2014/15
Calderdale & Huddersfield	14.45%	14.74%	14.90%	14.50%	15.09%

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

- At present there is no national 28 day readmission rate available. The data is not due to be released by the Health and Social Care Information Centre until 2016
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

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

- Better planned discharges lead to less readmission; discharge planning is one of the Trust priorities for the next year, and there are a range of interventions outlined in part 2 of this account.

20. Responsiveness to the personal needs of patients. (please note this section reflects the national patient survey,)

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

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

Question		2013		2014	
		CHFT Score	National Score	CHFT Score	National Score
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	7.3	7.3	7.6	7.7
Q34	Did you find someone on the hospital staff to talk about your worries and fears?	6.3	6.0	6.3	6.3
Q36	Were you given enough privacy when discussing your condition or treatment?	8.5	8.4	8.6	8.5
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	4.4	5.5	4.6	5.7
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.2	8.0	8.4	8.1
OVERALL EXPERIENCE		7.8	8.1	8.1	8.2

The Calderdale and Huddersfield NHS Trust intends to take the following actions to improve this score and so the quality of its services by: implementing the Patient Experience Improvement plan.



Patient Surveys

NATIONAL INPATIENT SURVEY 2014

	2012 Results	2013 Results	2014 Results	Change from 2013 to 2014
The emergency/A&E department (answered by emergency patients only)	8.5	8.7	8.6	↓
Waiting lists and planned admissions (answered by those referred to hospital)	8.9	9.0	9.0	-
Waiting to get to a bed on a ward	7.4	7.2	7.6	↑
The hospital and ward	8.3	8.3	8.2	↓
Doctors	8.4	8.5	8.6	↑
Nurses	8.4	8.4	8.5	↑
Care and treatment	7.6	7.8	7.9	↑
Operations and procedures (answered by patients who had an operation or procedure)	8.1	8.3	8.6	↑
Leaving hospital	7.2	7.3	7.3	↑
Overall views of care and services	5.0	5.2	5.8	↑
OVERALL EXPERIENCE	7.7	7.8	8.1	↑

SUMMARY

Overall, the trust has performed slightly better in the 2014 survey compared to previous surveys going from 7.8 to 8.1. In the 2014 Inpatient Survey, the trust has scored the same for Waiting List and Planned Admissions and has improved for most areas except for A&E departments and Hospital and Ward. This is shown in the table below with a comparison of previous years and also showing an increase or decrease from last year's survey.

Trust Comparisons by Question

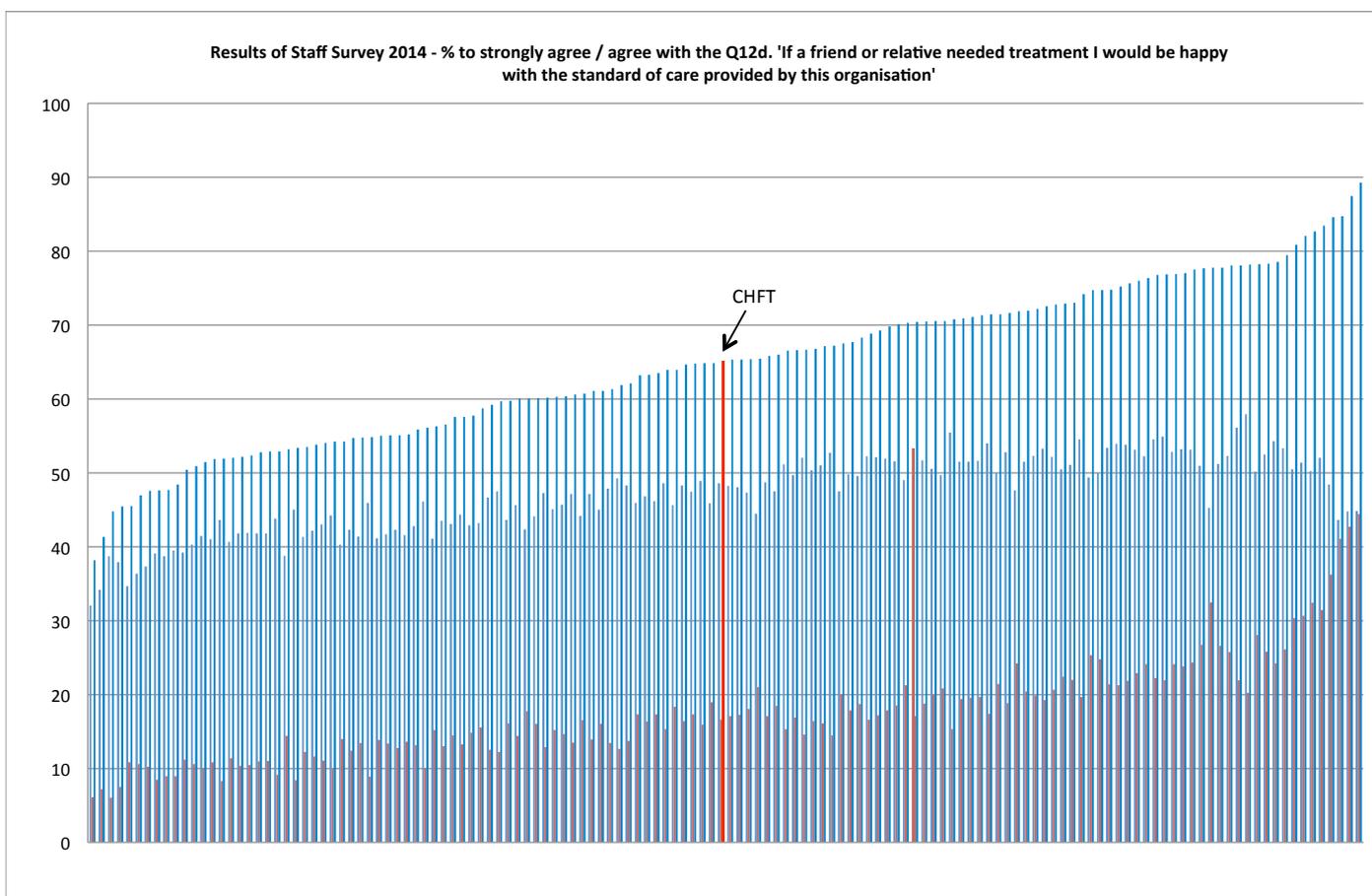
- In the 2014 survey, overall the trust has performed at a similar level to the 2013 survey and has continued to score highly in the patients experience on the Hospital and Ward section regarding feeling threatened by other patients or visitors and the availability of hand gels and also in Care and Treatment section regarding privacy when being examined or treated.
- This year, the trust has improved significantly on planning for a patients discharge and giving families information needed for care when patients leave the hospital going from 7.1 to 7.8. The trust has also scored better in this year's survey for patients being given full information when having an operation or procedure going from 8.9 to 9.1 and also for patients being treated with respect and dignity from 8.7 to 9.1.
- Even though the trust has stayed at a similar level for the last 3 years; some areas have not performed as well as previous years. These include patients not being given enough privacy when being treated in A&E going from 9.0 to 8.6, noise at night by other patients from 7.0 to 6.4 and patients being delayed on discharge and not given enough information regarding what they should and shouldn't do when leaving the hospital going from 7.2 to 7.0 and Q55 from 7.2 to 6.7.

	Patient responseFor each question in the survey, people's responses are converted into scores, where the best possible score is 10/10	Compared with other trusts Each trust received a rating of Better, About the same or Worse on how it performs for each question, compared with most other trusts.
The emergency/A&E department (answered by emergency patients only)	8.6/10	About the same
Information - for being given enough information on their condition and treatment in A&E	8.6/10	About the same
Privacy - for being given enough privacy when being examined or treated in A&E	8.7/10	About the same
Waiting lists and planned admissions (answered by those referred to hospital)	9.0/10	About the same
Waiting to be admitted - for feeling that they waited the right amount of time on the waiting list to be admitted	8.6/10	About the same
Changes to admission dates - for not having their admission date changed by the hospital	9.2/10	About the same
Transitions between services - that the specialist they saw in hospital had been given all the necessary information about their condition or illness from the person who referred them	9.2/10	About the same
Waiting to get to a bed on a ward	7.6/10	About the same
Waiting to get to a bed on a ward - for feeling they did not have to wait a long time to get to a bed on a ward, following their arrival at the hospital	7.6/10	About the same
The hospital and ward	8.2/10	About the same
Single sex accommodation - for not having to share a sleeping area, such as a room or bay, with patients of the opposite sex	8.7/10	About the same
Single sex bathrooms -for not having to share a bathroom or shower area with patients of the opposite sex	8.3/10	About the same
Noise from other patients - for not being bothered by noise at night from other patients	6.4/10	About the same
Noise from staff - for not being bothered by noise at night from hospital staff	8.2/10	About the same
Cleanliness of rooms or wards - for describing the hospital room or wards as clean	9.1/10	About the same
Cleanliness of toilets and bathrooms - for describing the toilets and bathrooms as clean	8.7/10	About the same
Safety - for not feeling threatened by other patients or visitors during their hospital stay	9.8/10	About the same
Availability of hand-wash gels - for hand-wash gels being available for patients and visitors to use	9.8/10	About the same
Quality of food - for describing the hospital food as good	5.1/10	About the same
Choice of food - for having been offered a choice of food	8.8/10	About the same
Help with eating - for being given enough help from staff to eat their meals, if they needed this	7.8/10	About the same
Doctors	8.6/10	About the same
Answers to questions - for doctors answering questions in a way they could understand	8.4/10	About the same
Confidence and trust - for having confidence and trust in the doctors treating them	9.0/10	About the same
Acknowledging patients - for doctors not talking in front of them, as if they weren't there	8.5/10	About the same
Nurses	8.5/10	About the same
Answers to questions - for nurses answering questions in a way they could understand	8.5/10	About the same
Confidence and trust - for having confidence and trust in the nurses treating them	9.0/10	About the same
Acknowledging patients - for nurses not talking in front of them, as if they weren't there	8.8/10	About the same
Enough nurses - for feeling that there were enough nurses on duty to care for them	7.5/10	About the same
Care and treatment	7.9/10	About the same
Avoiding confusion - For not being told one thing by a member of staff and something quite different by another	8.1/10	About the same
Involvement in decisions - for being involved as much as they wanted to be in decisions about their care and treatment	7.6/10	About the same
Confidence in decisions - for having confidence in decisions made about their condition or treatment	8.4/10	About the same
Information - for being given enough information on their condition and treatment	8.4/10	About the same
Talking about worries and fears - for finding someone on the hospital staff to talk to about any worries and fears , if needed	6.3/10	About the same
Emotional Support - for receiving enough emotional support, from hospital staff, if needed	7.7/10	About the same
Privacy for discussions - for being given enough privacy when discussing their condition or treatment	8.6/10	About the same
Privacy for examinations - for being given enough privacy when being examined or treated	9.5/10	About the same
Pain control - that hospital staff did all they could to help control their pain, if they were ever in pain	8.5/10	About the same
Getting help - for the call button being responded to quickly, when used	6.4/10	About the same

	Patient response For each question in the survey, people's responses are converted into scores, where the best possible score is 10/10	Compared with other trusts Each trust received a rating of Better, About the same or Worse on how it performs for each question, compared with most other trusts.
Operations and procedures (answered by patients who had an operation or procedure)	8.6/10	About the same
Explanation of risks and benefits - before the operation or procedure, being given an explanation that they could understand about the risks and benefits	9.1/10	About the same
Explanation of operation - before the operation or procedure, being given an explanation of what would happen	8.9/10	About the same
Answers to questions - the operation or procedure, having any questions answered in a way they could understand	9.0/10	About the same
Expectation after the operation - for being told how they could expect to feel after the operation or procedure	7.1/10	About the same
Information - for receiving an explanation they could understand from the anaesthetist or another member of staff about how they would be put to sleep or their pain controlled	9.4/10	About the same
After the operation - for being told how the operation or procedure had gone in a way they could understand	8.0/10	About the same
Leaving hospital	7.3/10	About the same
Involvement in decisions - for being involved in decisions about their discharge from hospital, if they wanted to be	6.9/10	About the same
Notice of discharge - for being given enough notice about when they were going to be discharged	7.5/10	About the same
Delays to discharge - for not being delayed on the day they were discharged from hospital	7.0/10	About the same
Length of Delay to discharge - for not being delayed for a long time	8.1/10	About the same
Advice after discharge - for being given written or printed information about what they should or should not do after leaving hospital	6.7/10	About the same
Purpose of medicines - for having the purpose of medicines explained to them in a way they could understand (those given medicines to take home)	8.2/10	About the same
Medication side effects - for being told about medication side effects to watch out for (those given medicines to take home)	4.6/10	About the same
Taking medication - for being told how to take medication in a way they could understand (those given medicines to take home)	8.3/10	About the same
Information about medicines - for being given clear written or printed information about medicines (those given medicines to take home)	7.8/10	About the same
Danger signals - for being told about any danger signals to watch for after going home	5.4/10	About the same
Home and family situation - for feeling staff considered their family and home situation when planning their discharge	7.7/10	About the same
Information for family or friends - for information being given to family or friends, about how to help care for them if needed	6.3/10	About the same
Contact - for being told who to contact if worried about their condition or treatment after leaving hospital	8.4/10	About the same
Equipment and adaptations in the home - for hospital staff discussing if any equipment, or home adaptations were needed when leaving hospital, if this was necessary	7.8/10	About the same
Health and social care services - for hospital staff discussing if any further health or social care services were needed when leaving hospital, if this was necessary	8.4/10	About the same
Overall views of care and services	5.8/10	About the same
Respect and dignity - for being treated with respect and dignity	9.1/10	About the same
Care from staff - for feeling that they were well looked after by hospital staff	8.9/10	About the same
Patients' views - during their hospital stay, being asked to give their views about the quality of care	2.4/10	About the same
Information about complaints - for seeing, or being given, any information explaining how to complain to the hospital about care received	2.8/10	About the same
Overall experience	8.1/10	About the same
Overall view of inpatient services - for feeling that overall they had a good experience	8.1/10	About the same

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

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



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

- The Trust's staff survey is based on a sample of 850 staff of which 822 were eligible to complete the survey. The response rate was 45% - making a total of 370 staff who participated in the survey.

The staff survey score for indicator KF24 with contributing questions:

Question/ Indicator	CHFT 2013-14	CHFT (compared to national) 2014-15	National 2014-15
Q12a Care of patients/service user is my organisations top priority	72	70	70
Q12b My organisation acts on concerns raised by patients /service users	71	70	71
Q12c I would recommend my organisation as a place to work	62	57	58
Q12d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	68	65	65
KF24 (Overall Indicator) Staff recommendation of the Trust as a place to work or receive treatment	3.74	3.67	3.67

Staff recommendation of the Trust as a place to work or receive treatment is 3.67; the score in the 2013 survey was 3.74 out of 5. This is a small reduction in performance against the previous years' survey.

Looking at the survey as a whole the following table shows where the Trust performed in the best 20% or worst 20% than the national average.

Indicator	CHFT	National	Top or Bottom 20% of Trusts
KF7 staff appraised in last 12 months	91%	85%	Top
KF13 reporting errors, near misses or incidents witnessed in the last month	94%	90%	Top
KF22 able to contribute towards improvements at work	72%	68%	Top
KF27 belief that the trust provides equal opportunities for career progression or promotion	91%	87%	Top
KF28 experiencing discrimination at work in last 12 months	9%	11%	Top
KF17 experiencing physical violence from staff in last 12 months	4%	3%	Bottom
KF26 having equality and diversity training in last 12 months	45%	63%	Bottom

Of the 29 key findings, 11 have shown improvement since 2013, one has remained the same, 15 have deteriorated and two cannot be compared due to changes in the questions.

The Trust scored well in each of the sub-dimensions for staff engagement and above average for the overall staff engagement indicators. It was ranked in the top 20% of Trusts for K22 'staff ability to contribute towards improvements at work (the extent to which staff are able to make suggestions to improve the work of their team, have frequent opportunities to show initiative in their role, and are able to make improvements at work'.

There are some positive improvements in the perception of quality of care. For example, 67% of staff said they thought patient care was the top priority for their organisation compared to 66% in 2013. More than three quarters of staff reported that patient experience measures are collected in their organisation and 50% said such feedback is used to improve patient care.

A new question on raising concerns shows that 68% of staff would feel safe to raise a concern about unsafe clinical practice and 93% would know how to do so.

The Trust has a colleague engagement strategy which has at its core four behaviours that the Trust expects to see across the organisation. The Trust continues to work to embed these key values through its Working Together, Get Results programme.

The behaviours are:-

- We put the patient first – we stand in the patient's shoes and design services which eliminate unproductive time for the patient.
- We 'go see' - we test and challenge assumptions and make decisions based on real time data.
- We work together to get results - we co-create change with colleagues creating solutions which work across the full patient journey
- We do the must-do's - we consistently comply with a few rules that allow us to thrive.

The programme is aimed at achieving a consistent approach to how change is managed, in particular to ensure it fully engages the potential and creativity of staff and allows colleagues to work across divisional and organisational boundaries. There are simple and practical tools that help leaders engage colleagues in a way that allows breakthroughs in their ability to lead transformational change in the organisation. Properly applied the tools secure the commitment of colleagues to the organisation's vision and values and ensures colleagues are motivated and contribute to delivering the Trust vision:

In respect of the staff survey feedback the Trust plans to develop and agree actions for sign off by the Well Led Group in May and for that to progress to Quality Committee, Executive Board and the Board of Directors in the same month. The intention is to test the response with a range of colleagues between these meetings including those who participated in the Picker 2013 survey focus groups. The Trust also intends to use Picker to independently share the key messages from the survey in the organisation. In the meantime, colleagues will be updated Trust-wide about plans to progress action planning.

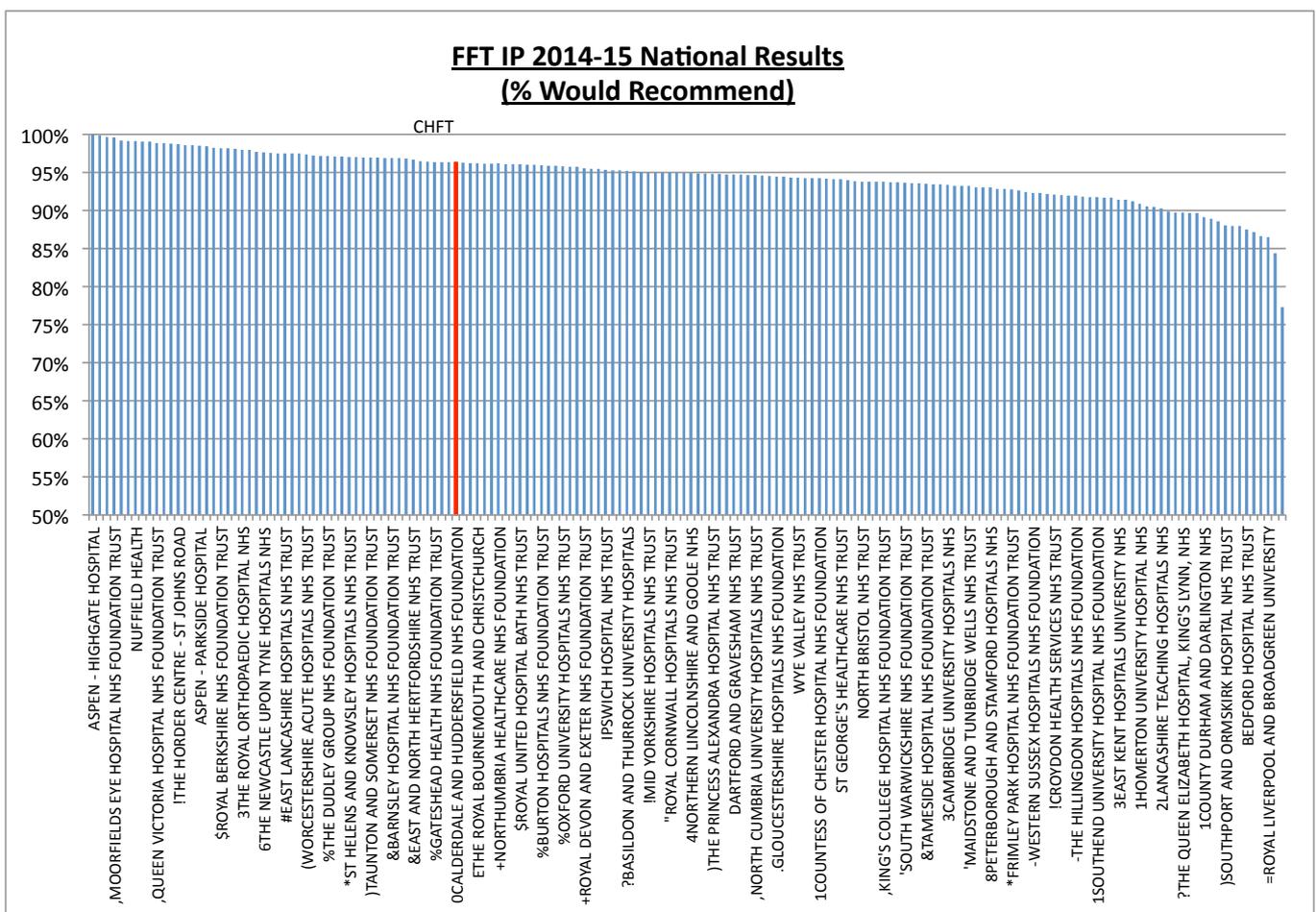
In addition there are some more immediate actions that the Trust plans to take/has taken:

- Building on significant risk/health and safety and equality and diversity training developments in 2014 a refresh of the approach to mandatory and essential skills training to improve access has been undertaken and will be considered for approval by the Trust's Executive Board in May.
- A mental health well-being and stress management policy was approved in March 2015.
- A health and well-being strategy with a supporting calendar of activities to promote colleague well-being is under development.
- Through the Trust's raising concerns/whistleblowing activity improving the feedback to colleagues on changes made when issues/concerns are raised is being improved.
- The Trust is exploring the opportunities to influence behaviour of patients towards employees and to the provision of a safe and secure work environment for colleagues.
- In addition to the annual staff survey, where the friends and family questions are asked, the Trust also provides an opportunity for all staff to access the Staff Family and Friends Test on a quarterly basis.

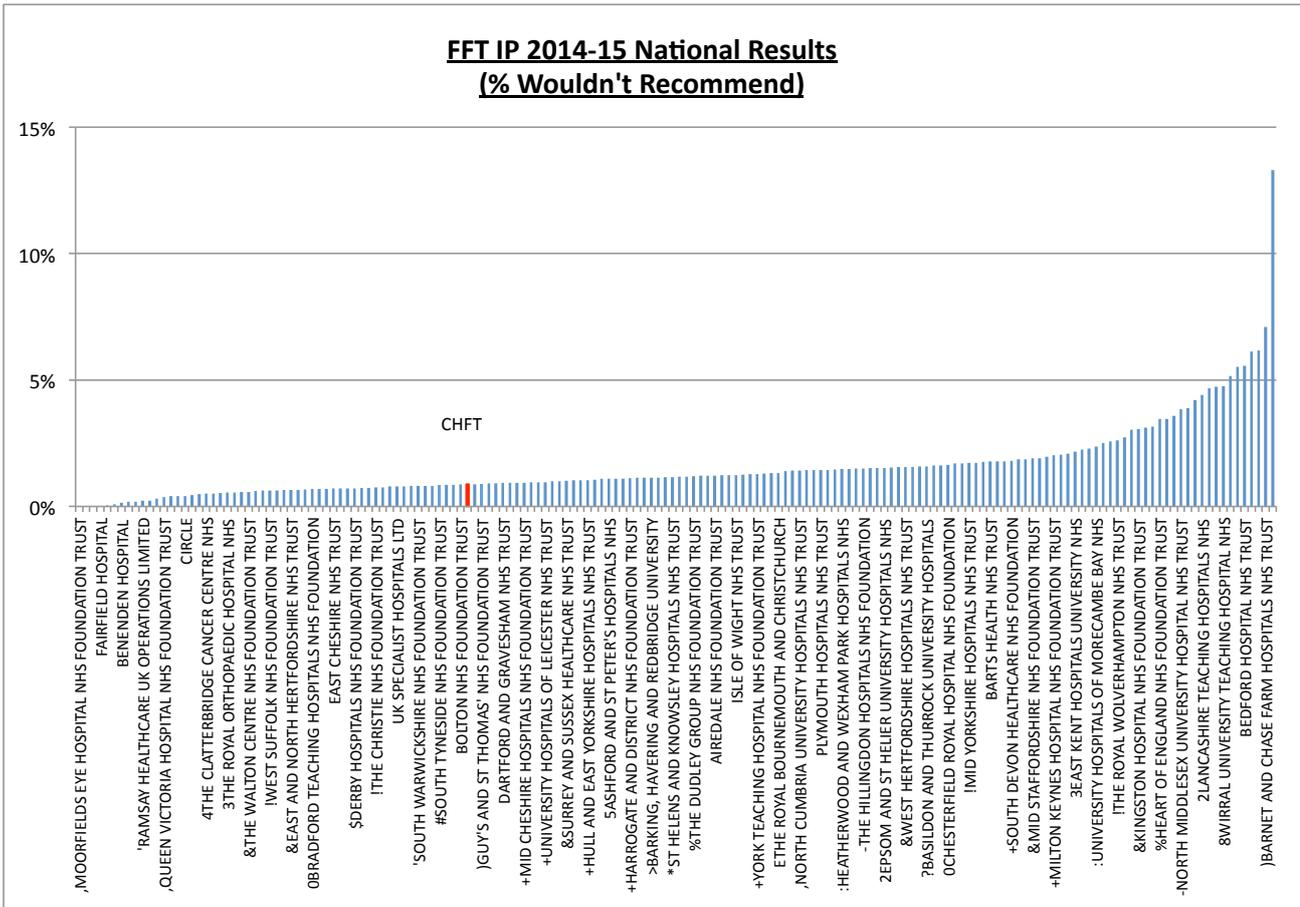
Patient element of friends and family test (FFT)

The Friends and Family Test is a question that has been asked to all inpatients over 16 in NHS hospital trusts since April 2013. The question asks "How likely are you to recommend our ward to friends & family if they needed similar care or treatment?" Up until October 2014 this was a Net Promoter Score (NPS) which is calculated on a scale of -100 to 100; following a review by NHS England a decision was made to introduce a more transparent presentation of the data which the patients and staff would find easier to understand and use. The outcome is that results are now presented as a % of patients who would recommend the service and the % of patients who would not.

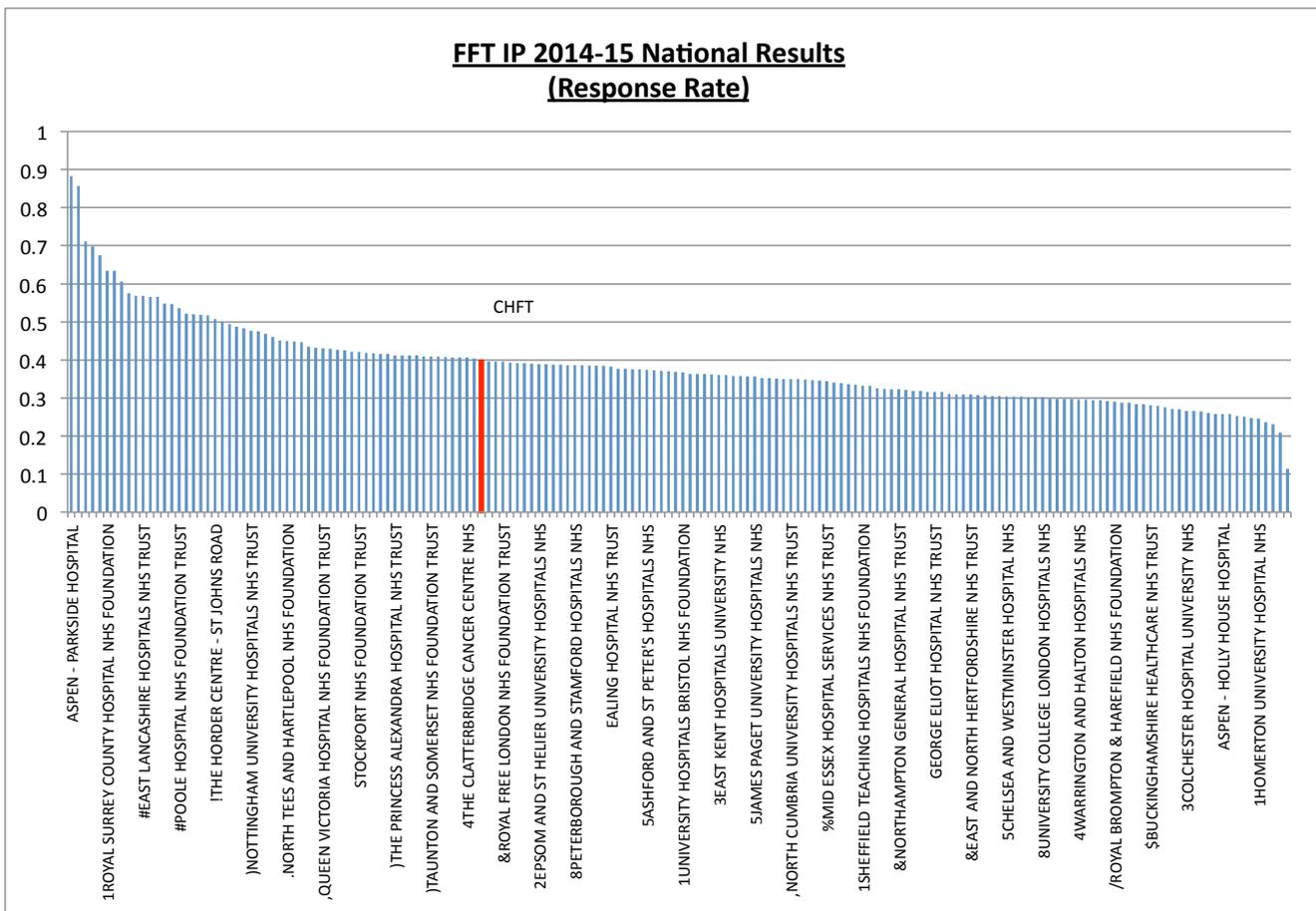
The chart below shows the % of patients who would recommend care or treatment by individual Trusts between April 2014 and February 2015 – CHFT is highlighted in red. The data shows that the Trust is in the top 1/3 of Trusts.



- The chart below shows the % of patients who would NOT recommend care or treatment by individual Trust between April 2014 and February 2015 - CHFT is highlighted in red.



- The Trust is ranked 58th out of 170 trusts in response rate, an improvement on last year's position.

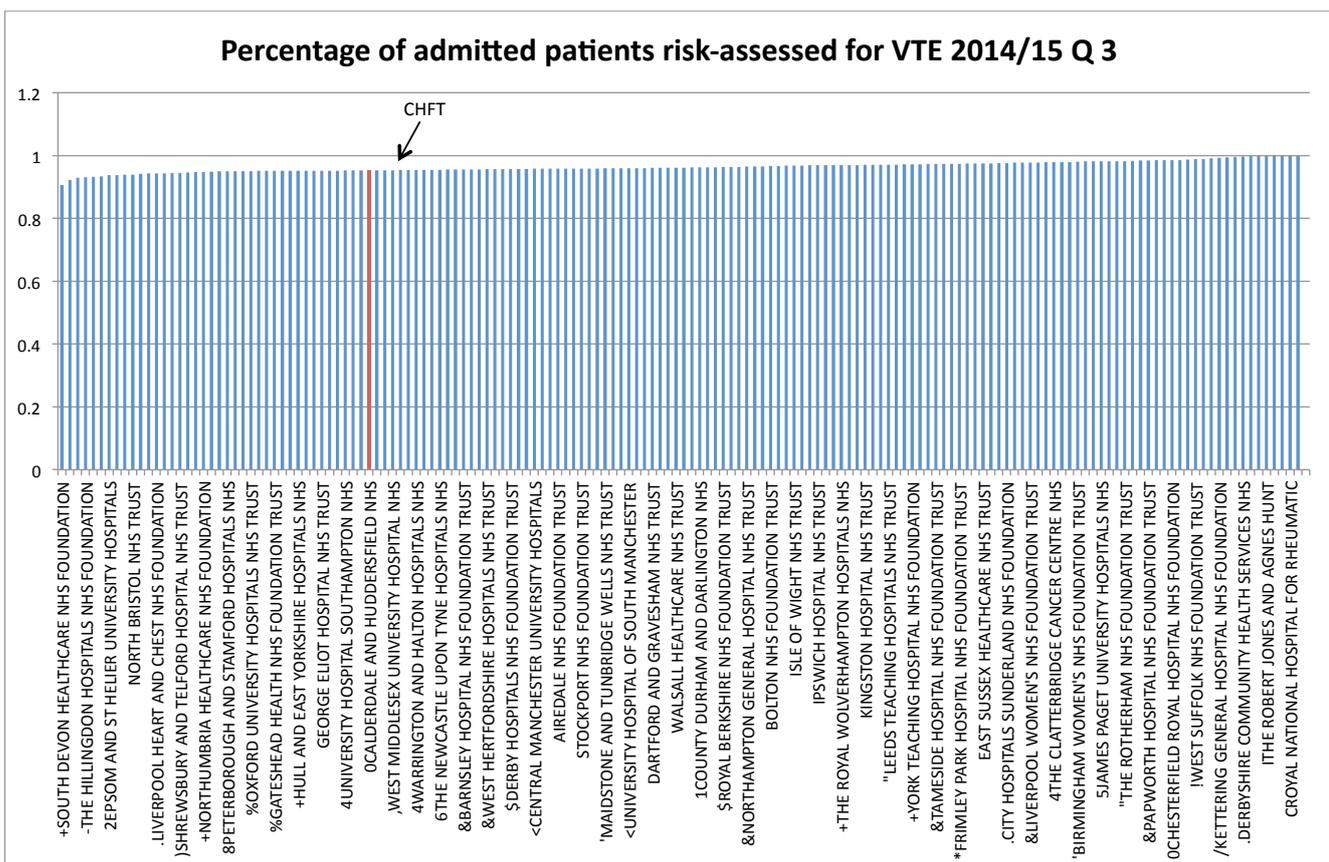
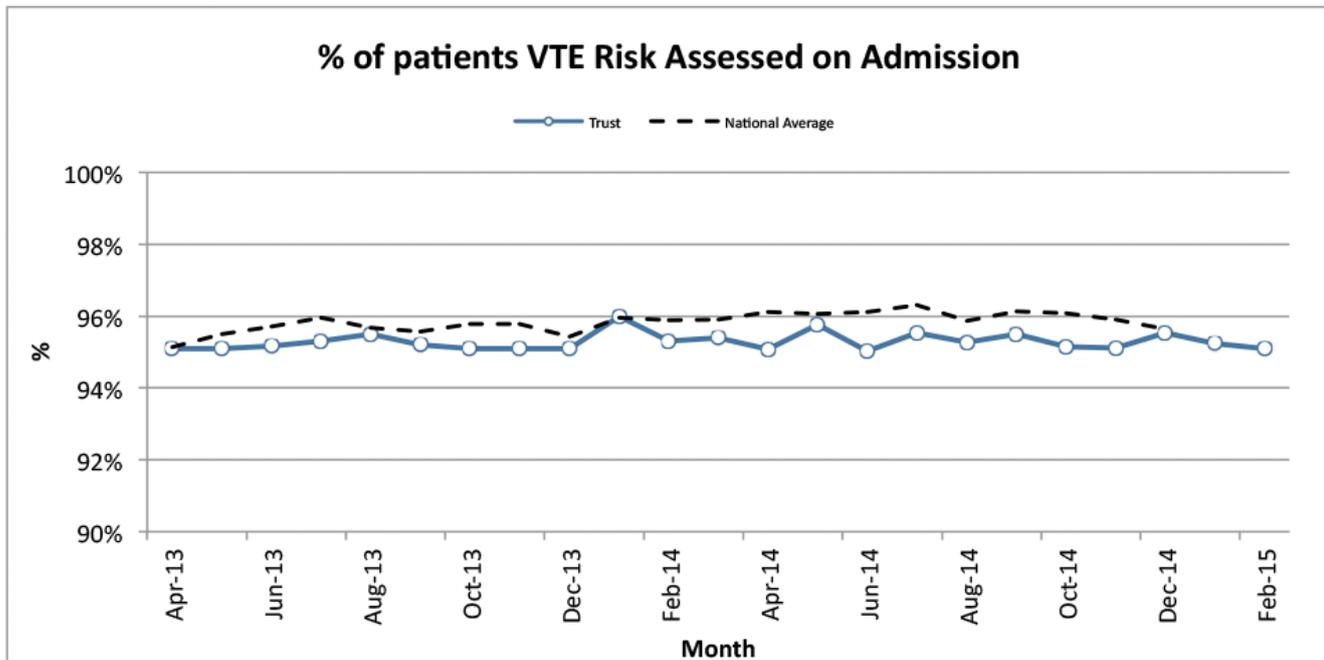


The Calderdale and Huddersfield NHS Trust has taken the following actions to improve this percentage and also the quality of its services:

- In order to promote improvement, scores are provided monthly at ward level. The comments collected through the friends and family test process are also made available to allow the Trust to gain a better understanding of patient perception and to plan interventions when necessary.
- A walk round on all medical wards was carried out asking staff to explain their processes for getting FFT responses and how the information was being used to make improvement in the clinical areas. The results were fed back to teams and to continue this work, six-weekly meetings are in place to discuss responses and share good practice.

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

The charts show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from April 2013 to February 2015.



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

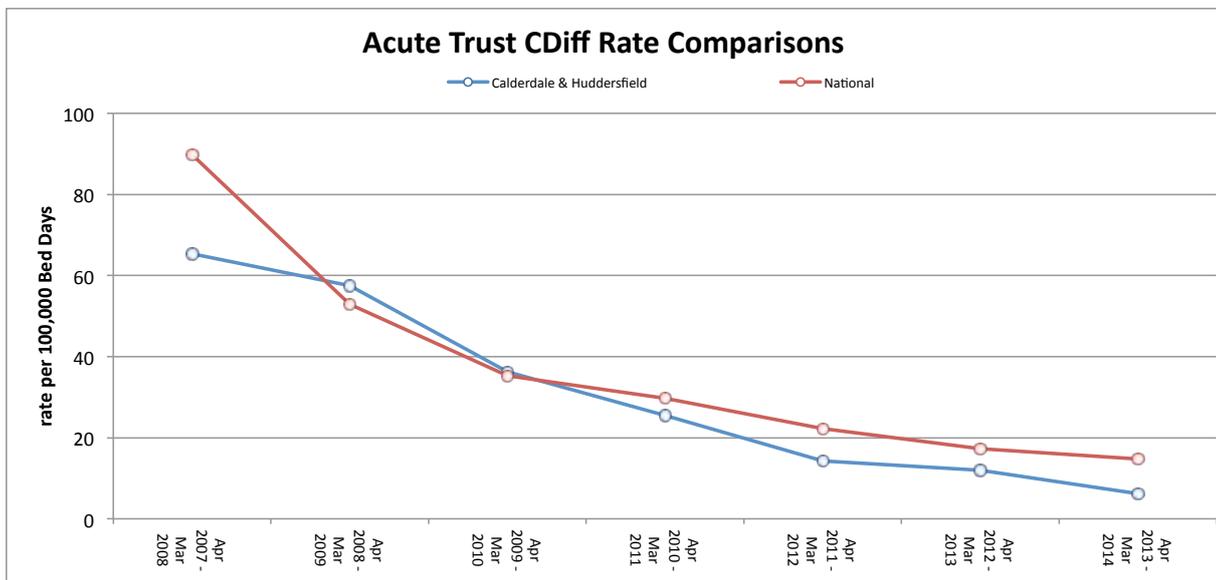
The target from December 2012 for VTE risk assessment for all patients admitted was set at 95% and this has been consistently met. The benchmarking graph shows the Trust to be in the bottom third of Trusts, however issues with data capture make it difficult to evidence performance above the 95% target.

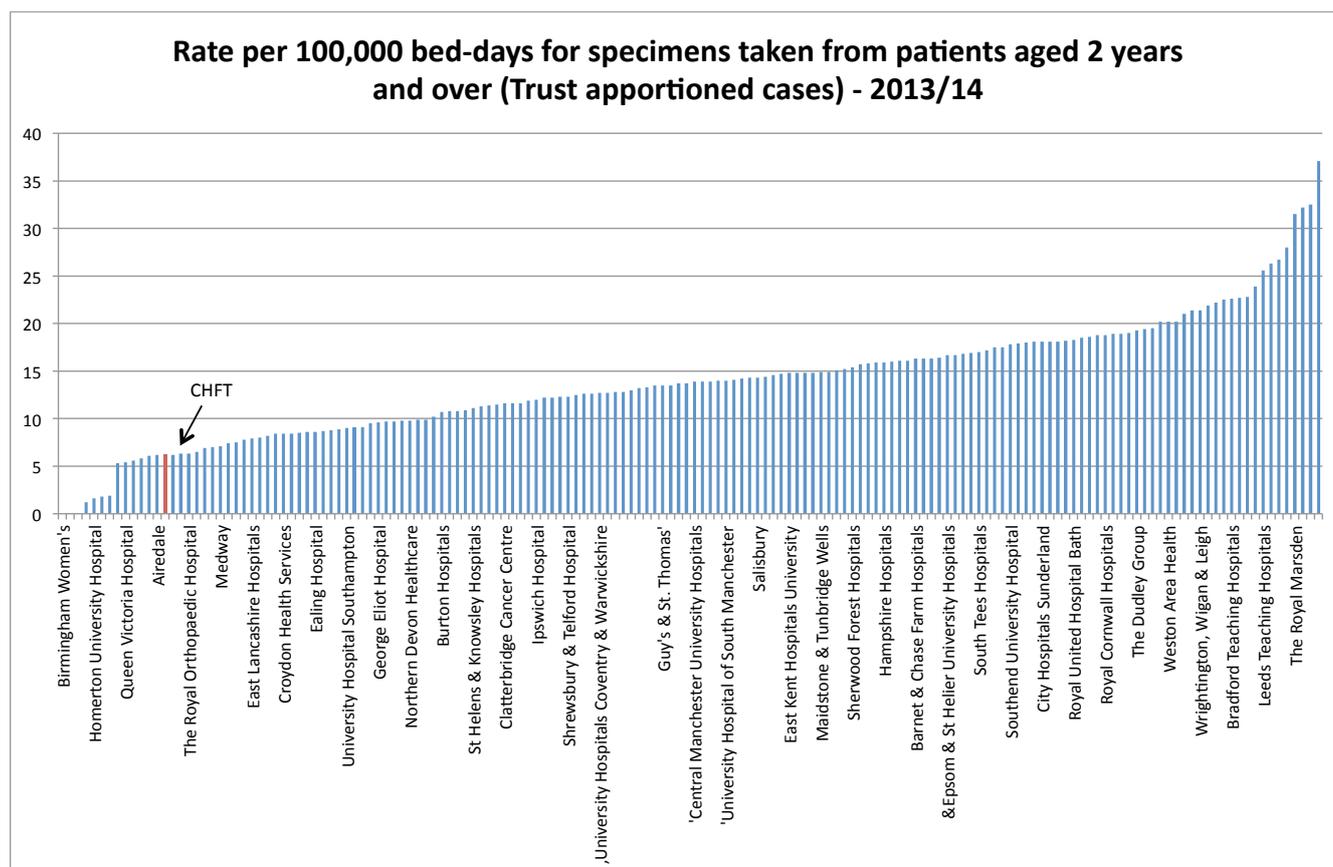
The Calderdale and Huddersfield Foundation Trust have taken the following actions to improve this and so the quality of its services:

- Compliance data is currently retrieved manually after the patient has been discharged from hospital. To improve reliability of data and patient care, work is underway to have the VTE assessment incorporated on the nerve centre (electronic assessment system) for doctors to complete. This will allow data on compliance with the process to be reviewed live so any issues can be addressed immediately. In addition to this the system will include a prompt the doctors to review the VTE assessment after 24 hours.
- There is a reliable process in place to ensure that when hospital associated VTEs are identified they are investigated for any failings of care and actions taken wherever necessary.

24. Rate of Clostridium-difficile infection

The chart shows the rate per 100,000 bed days of cases of Clostridium-difficile infection reported within the Trust amongst patients aged two or over during the reporting periods from April 2007 to March 2014.





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

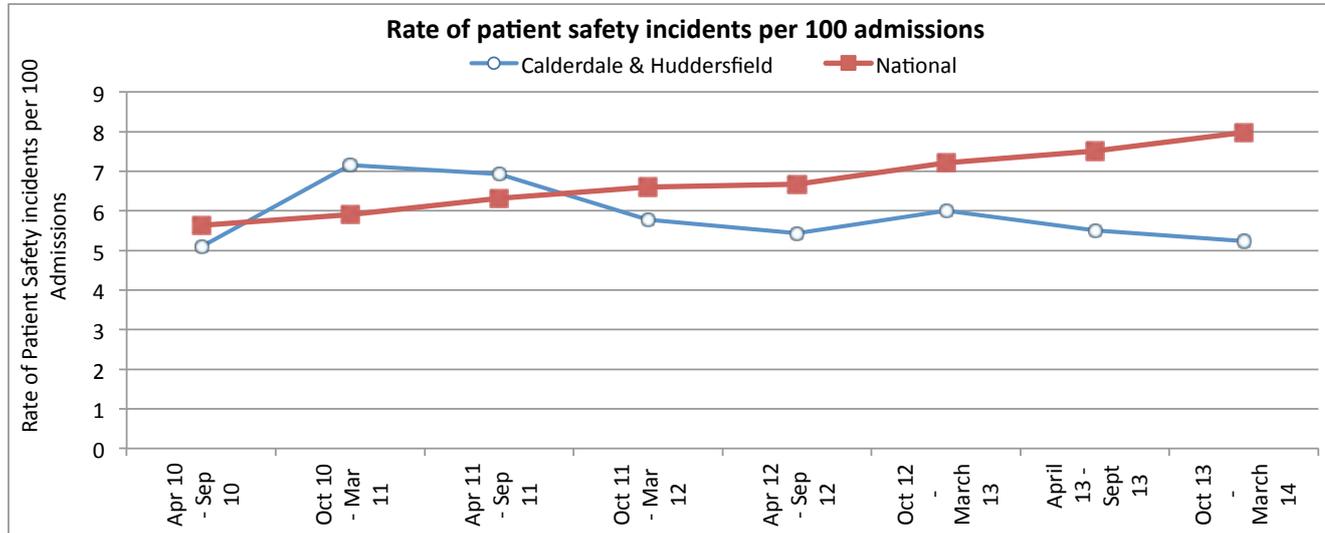
- The Trust continues to report all data externally via the Public Health England data capture system and internally to the Executive Board and Board of Directors monthly.
- The charts show a reduction in Clostridium cases and have remained below the national average throughout 2010 and 2014.
- The second chart shows that in 2013/14 the Trust performed very well when compared to other similar NHS organisations

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

- Strict adherence to personal protective equipment policies and protocols, additional signage and use of hand hygiene with soap and water
- Mandatory training for all clinical staff and new starters
- Continuing to manage patients with C-difficile on an evidenced based specific pathway
- Continue to review all patients with C-difficile by a specialist infection prevention and control nurse using a daily checklist and escalating any issues immediately
- Routine use of Hydrogen Peroxide Vapour (HPV) decontamination of all rooms where patients with C-difficile have been treated after they are discharged
- Regular infection control and antibiotic ward rounds with a microbiologist
- Continued collaborative working with Matrons
- Root Cause Analyses of every single case of hospital acquired C.difficile to ensure that lessons are learned to prevent future infections

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

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



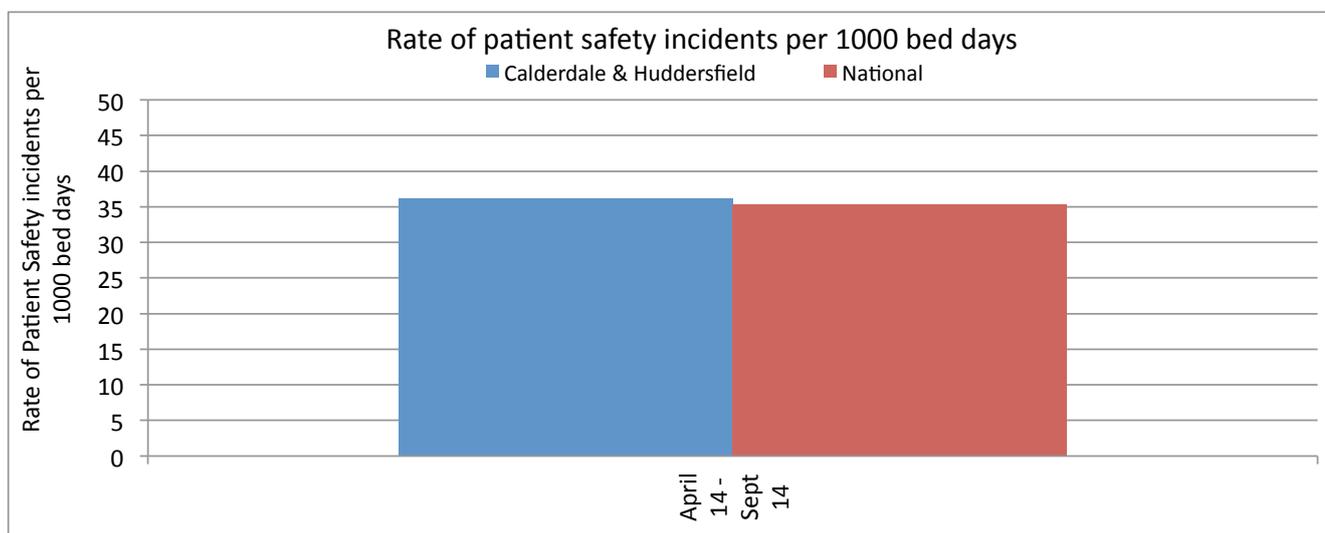
The Calderdale and Huddersfield NHS Trust considers that this data is as described for the following reason:

The chart above shows the Trust’s previous reporting on the National Reporting and Learning System. This shows that the Trust was slipping down the table in terms of the number of patient safety incidents reported. Over the last 12 months two important changes have been made to reporting processes: 1) the number of patient incidents uploaded to NRLS has been increased as there has been an increased focus on the importance of reporting incidents and 2) the severity scoring rating has been changed to reflect actual harm caused.

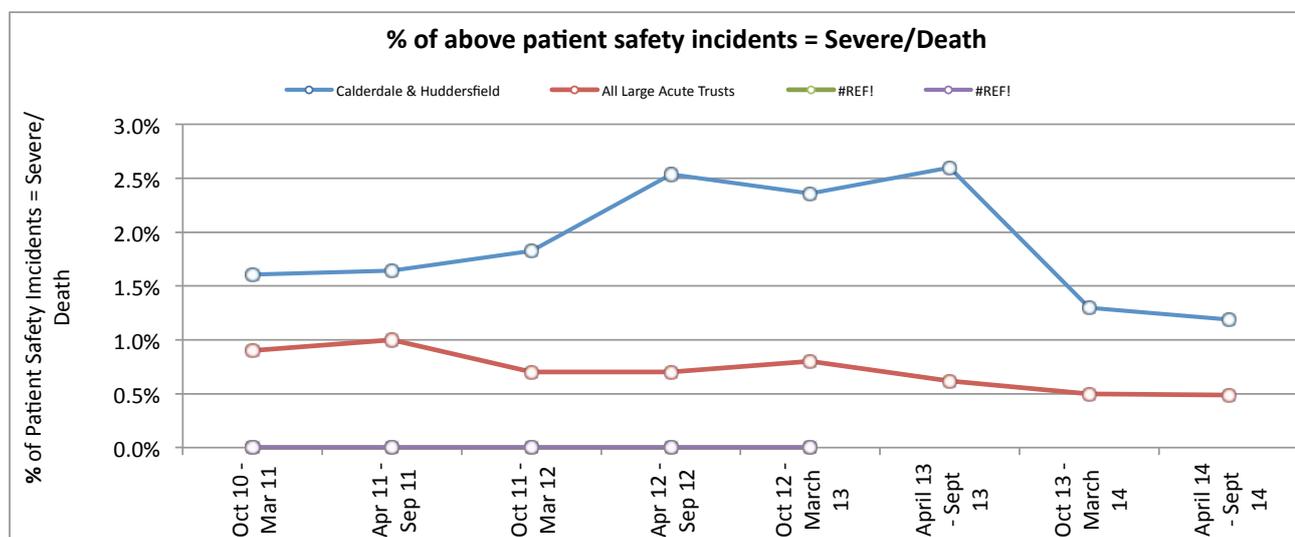
The above have resulted in an improved position in the recently published NRLS reports yet to be reflected in the national dataset.

It should be noted that NHS England has changed the way that they have reported in the latest report: the first change is that there is now an “Acute” hospital type (it used to be acute large/Acute teaching/other). This has resulted in the Trust being benchmarked within 140 Trusts as opposed to 38. The second change is that incidence rate is now calculated by 1000 bed days as opposed to 100 admissions. This has changed the ratio from 5 to 36. As a result of this change we are unable to provide graphs to demonstrate the improvement based on previously published reports.

The chart below shows the data set from April to September 2014 based on the new way of calculating the rate. It illustrates the improvement with the Trust now reporting above the national average.



The following chart shows the % of incidents graded as severe harm or death.



The Trust reports a higher rate of severe/death patient safety incidents than other large acute trusts. This is attributable to the type of incidents the Trust views as severe patient safety incidents compared with other large acute trusts, for example, all category 3 and 4 pressure ulcers are viewed by the Trust as severe harm and any patient who sustains a fractured neck of femur whilst in the care of the Trust is also reported as severe harm. This reflects the seriousness with which the Trust views these incidents and grading and in this way ensures the correct level of investigation is carried out and appropriate actions taken to reduce their incidence in future. In addition the Trust had been grading the severity of incidents on the impact “risk” to the patient rather than the actual harm caused. This has now been altered in line with national guidance and the severity rates have fallen. This is not yet reflected in the national datasets.

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

- In January 2014, the Trust introduced DatixWeb, an on-line incident reporting tool. The aim of this was to provide an accessible system which could provide instant reporting and up to date data. This also enables the service manager to review and undertake an initial investigation into the incident to establish whether this has been managed satisfactorily or needs to be escalated.
- The Trust has introduced a 48hr serious incident panel (chaired by Director of Nursing/Medical Director) where potentially serious incidents are discussed and agreed within a short period of time following the event. This panel also considers what immediate actions may be needed to prevent a recurrence.
- Introduction of timescales for completion of incident investigations (45/60 days in line with the national serious incident framework).
- Introduction of sign off of serious incident investigation reports at a panel (again chaired by Director of Nursing/Medical Director).
- Improved reporting to the national learning and reporting system (NRLS).
- Continued patient safety improvement work on areas of concern (i.e. falls and pressure ulcer collaborative).
- One of the largest areas where improvement can be made is around ensuring that events are properly investigated to ascertain the root cause and any actions agreed and delivered will reduce the chance of the event re-occurring. The current investigations process is being reviewed including designing a toolkit to aid effective investigations from simple incidents through to complex serious harm events. To support this training for investigators is being designed to ensure there is clarity of aims and investigators have the skills and knowledge to get to the root cause. In addition the Trust's current risk management system DatixWeb is being revised so it is better able to pull out causes of harm and analyse at this level to promote and inform change.

There have been no Never Events in the Trust this year.

• Type and Severity of Incidents

6,771 patient safety incidents were reported in 2014/15 (8,924 if you include those incidents reported but allocated to another organisation). Of the 6,771 incidents, 1,641 resulted in harm, mostly minor harm (87%).

In 2014/15, Calderdale & Huddersfield NHS Foundation Trust changed the criteria of severity rating harm incidents from the risk of harm which may be caused to the actual level of harm caused to the patient. This brought us in line with the reporting requirements for the NRLS. This has resulted in a decrease in the number of severe harm (classed as red) incidents reported and an increase in the number of moderate harm (classed as orange) incidents. An investigation is undertaken for all orange and red incidents.

All red severity incidents are reported to the Clinical Commissioning Group (CCG) under the National Serious Incident Framework. Of the 106 incidents reported to the CCG in 2014/15, 95% related to category 3 (87) and 4 (14) pressure ulcers. Overall when analysing categories by level of harm, the top three issues for the year are: Falls, Pressure Ulcers and 3rd degree/4th degree tears. All of which have dedicated improvement work looking at cause and reducing the risk of occurrence.

Type and Severity of Complaints

The total number of concerns and complaints received has increased by 6% 2014/15. Within this total there is a 7% increase in complaints and an 8% decrease in concerns.

The key areas of issues raised across concerns and complaint remain access; communication and treatment, however the ranking is different between concerns and complaints.

In concerns the top issues raised relate to access to services, then communication followed by treatment.

In complaints the top issues raised relate to treatment, then communication and access to services.

All complaints are assessed, upon receipt, in terms of severity. This year there has been a slight reduction in the number of red (extreme) severity complaints 22 compared to 27 last year, and a significant increase in the number of orange (high) severity complaints from 57 last year to 142 this year.

A new process has been introduced for complaints assessed as red (extreme) severity. The Division are given approximately two weeks to undertake a preliminary investigation which is then discussed at a Complaints Panel (chaired by the Deputy Director of Nursing or the Assistant Director for Quality). The panel considers the findings, any additional action that needs to be taken and how the complaint will be resolved.

Over the year we have been introducing improvements to the way we handle complaints as we strive to ensure:

- Everyone feels confident to speak up if they are worried about any aspect of their care
- It is simple and straightforward to raise concerns and complaints
- We listen and understand the issues raised and make sure we agree how we will address these
- We respond in the way we agreed and the timescale we agreed
- We show the changes that are made as a result of the issues raised.

Parliamentary Health Services Ombudsman (PHSO) Complaints

In the past 12 months, we are aware of 21 cases being raised that have led to an investigation with the PHSO, compared to 11 the previous year. This reflects a change of approach by the PHSO to investigate more cases.

Of these 21:

- 7 were not upheld or discontinued;
- 3 were resolved following further action;
- 9 are currently under review by the PHSO (who are currently experiencing a backlog)
- 2 were partly upheld and recommendations completed.

Information Commissioner

We have not had any complaints investigated by the Information Commissioner.

Outcomes of Complaints received

Of the complaints closed to date, 33% have been upheld; 37% partially upheld and 30% not upheld. Over the year 32% of complaint responses have been made within the agreed timescale.

The Trust has changed its internal processes to provide close monitoring of the investigations being carried out and introduced improved key performance indicators. Performance against these are reported monthly to the Patient Experience and Caring Group and through a monthly performance report to the Trust Board.

A quarterly quality report to the Trust Board provides detailed analysis of the issues being raised through complaints and concerns.

Key themes and learning from Complaints

Communication is a large issue in complaints, and is raised as a specific issue of complaint in 50% of all complaints received. Themes raised in complaints regarding communication relate to patients feeling that they are not being treated as individuals; not being listened to and staff not being aware of their individual situations.

The introduction of courtesy rounds in all areas is expected to improve communication with patients and families.

The following are examples where learning from complaints has helped lead to changes:

- New leaflet used by the Leeds cancer service included in patient information pack.
- Flexible visiting time introduced for relatives of patients with advanced cancer but not yet on end of life care plan but would find comfort for family members to be close.
- "Scheduling" of appointments introduced in 'System 1' to prevent missed visits by community staff.
- Improving provision of palliative support during weekends to enable regular discussion with family.
- Letter being sent to women following colposcopy revised to provide better explanations of what happens next.
- Additional staff recruited to enable increased therapy provision on Stroke Rehabilitation.
- Frenulotomy service reviewed and business case completed for training of additional frenulotomy skills.
- A quiet room was created to have discussions with families and new boards introduced behind each bed soon to highlight what is important to the patient and relatives.
- New leaflet completed to help ensure women understand the induction of labour process.
- Patient helping to develop angiography service leaflet from patient perspective.
- Pressure Ulcer Prevention and Management Plan developed for the children's ward. (Glamorgan Scale)
- Stone Management System and Stent Register established to enable monitoring of all patients with a stent.

Common issues raised in complaints were also used to inform the patient experience work streams for example the 'Hello My Name Is' campaign.

Part 3

Performance on selected quality indicators

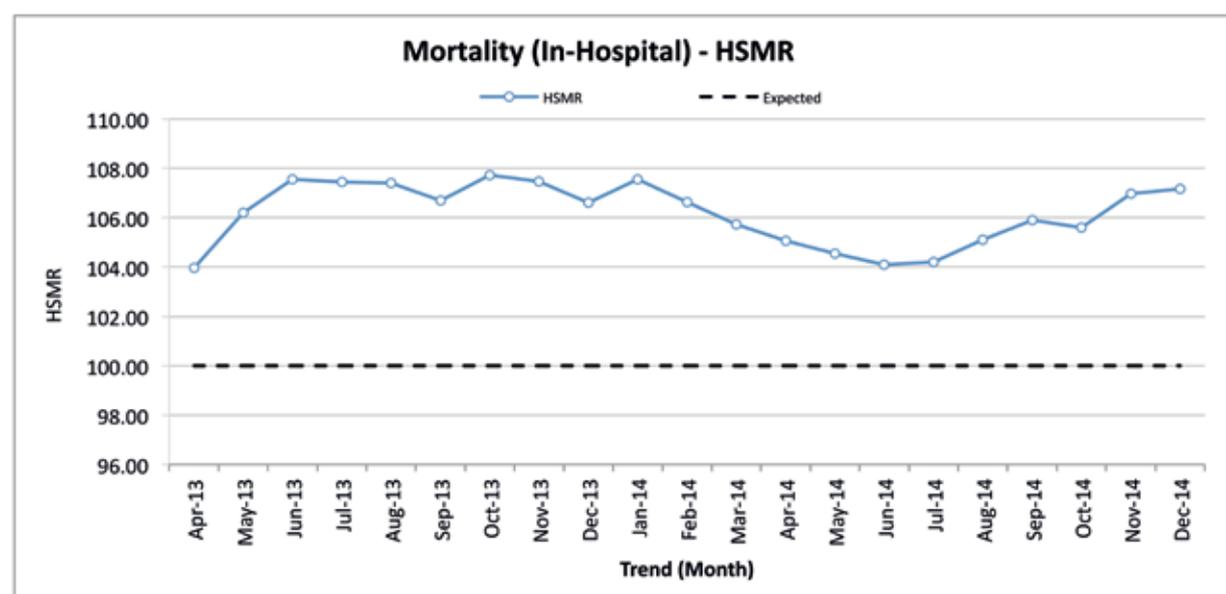
This section provides an overview of care offered by the Trust based on its performance in 2014/15 against indicators selected by the Trust Board in consultation with stakeholders, with an explanation of the underlying reason for selection.

The indicators are as follows:

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

Hospital Standardised Mortality Rate (HSMR)

HSMR is a national measure that the Trust uses to compare its mortality rate with that of other English trusts.

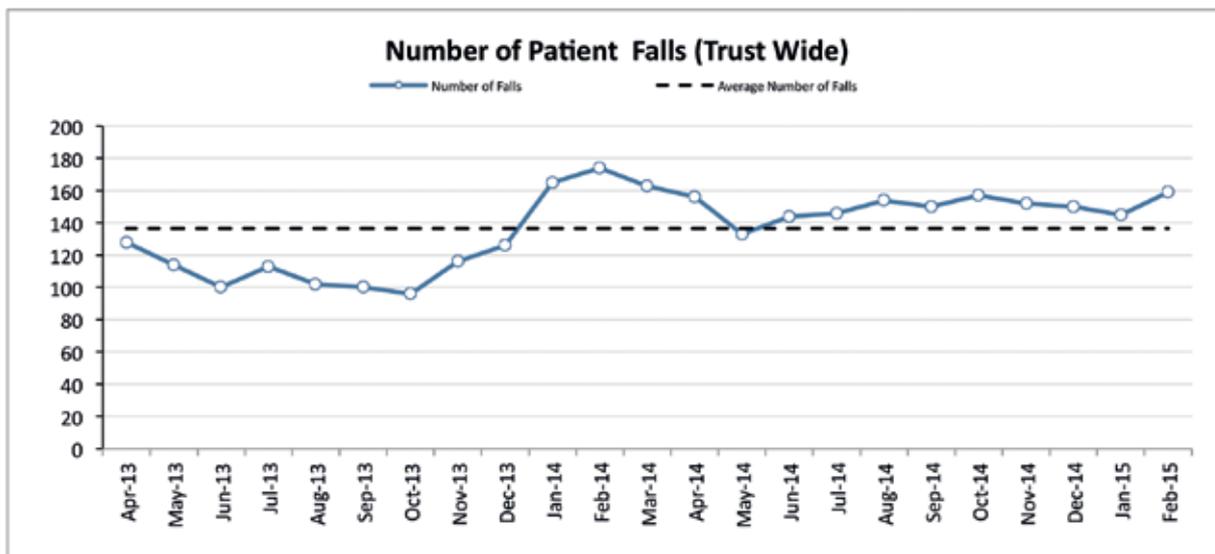


HSMR is a national measure that the Trust uses to compare its mortality rate with that of other English trusts. On the chart the dotted 100 line indicates the expected rate of overall deaths for the Trust (the relative risk). The Trust aims to maintain its score below this line as this tells us there is a lower than expected mortality rate for our population.

It has been recognised that HSMR is only one indicator of mortality and this measure must be used in conjunction with SHMI, crude mortality as well as a robust system for mortality review. This is to ensure a true picture around care quality and preventability is seen and can be acted upon. The Care of the Acutely Ill Patient programme uses all these metrics as its key outcomes.

Falls in Hospital

Hospital falls continue to be the highest reported safety incident in the Trust and therefore remain a priority for improvement.



The chart shows the number of falls patients have had whilst in hospital, on average this was 137 per month. In addition to the total number of falls reported the Trust also measures falls that result in harm.

As the chart shows there was initial improvement in the number of harm falls through 2013 although this has now stabilised.

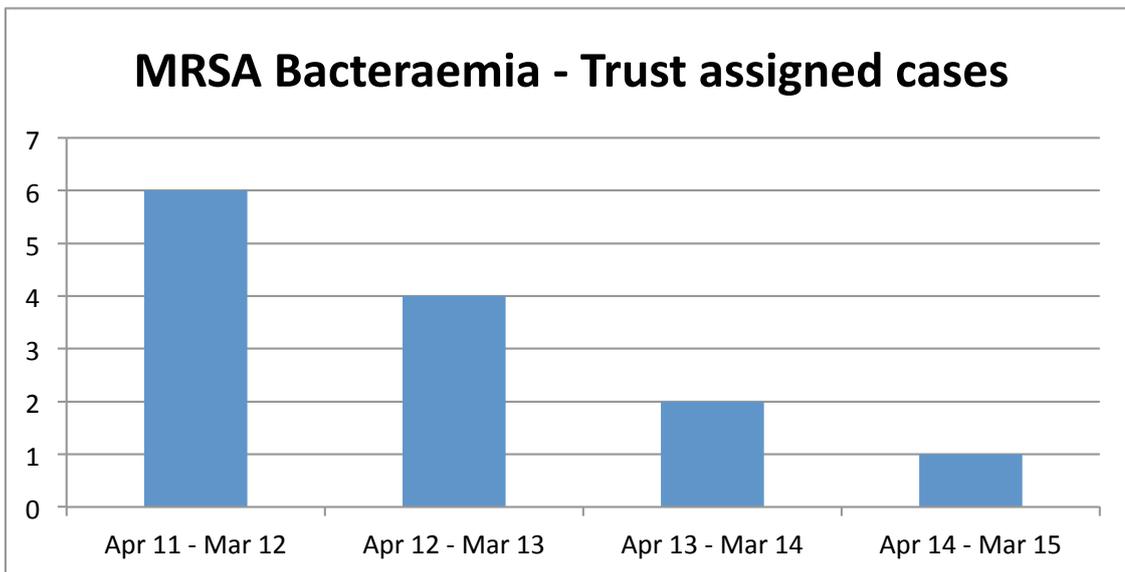
Throughout 2014-15 the work of the falls collaborative has been focussed around designing new documentation to better reflect the national evidence base for falls prevention, these tools have been available in all clinical areas since January 2015.

- The first thematic review of red and orange incidents for falls took place on the 25 November 2014. This highlighted poor compliance with care bundles and lack of person centred care planning. This review will be repeated in April 2015 and the information cross referenced to the interventions and new documentation the Trust has in place to ensure these will address all the root causes of falls.
- On two wards a safety briefings process has been tested and is now in place, this is led by senior clinicians. On one ward this has had a dramatic effect on reducing falls. The immediate plan is to recruit another two clinicians willing to test and implement this on their wards.
- The first national falls audit is taking place on May 12 and 13 2015. The audit looks at assessment and documentation. Results will be used to inform the work.

Healthcare associated infections (HAIs)

Mandatory indicator 24 sets out the Trust's on-going plans for further reduction of Clostridium-difficile.

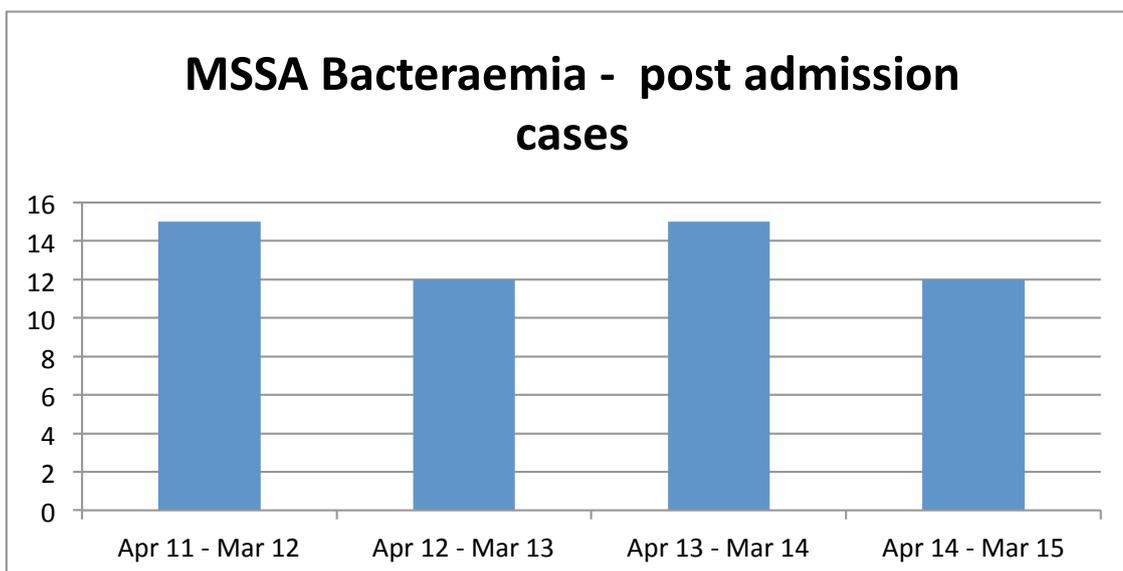
The following is an explanation around other key infections the Trust has targeted improvement work in place to address.



The Trust has seen a year on year reduction of MRSA (Meticillin resistant Staphylococcus aureus) bacteraemia cases over the last four years. This has been due to the hard work of all the clinical teams to improve hand hygiene, care of invasive devices with earliest removal, improved communication and MRSA screening of patients. Continued work has seen improvements in cleanliness across all ward areas with frontline ownership from ward managers and charge nurses to keep their areas tidy and organised.

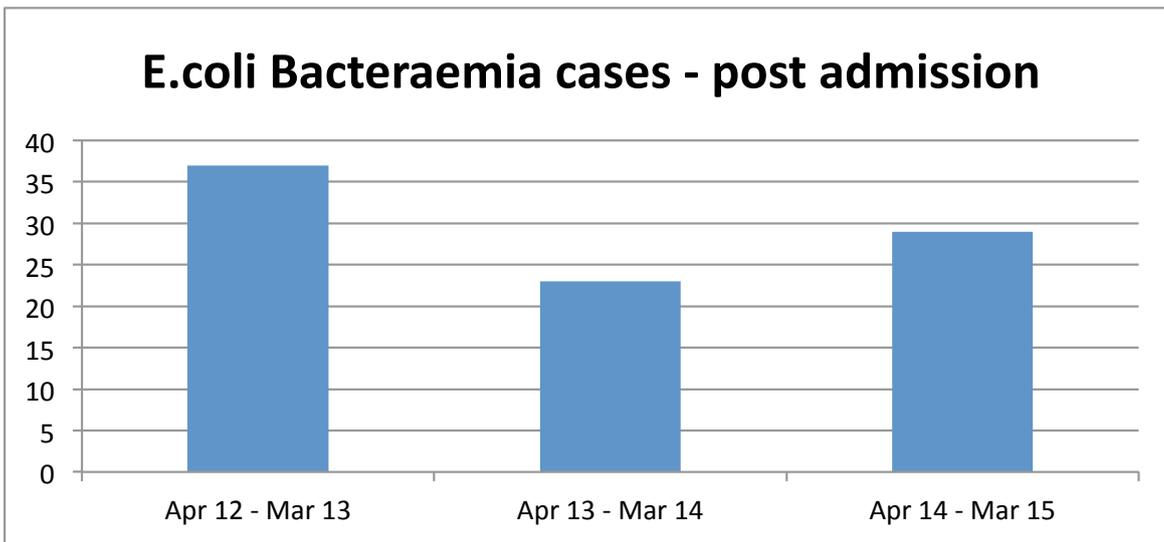
The infection prevention and control team visit the wards to review patients and promote high standards of infection prevention and control practice. In addition the Microbiology Consultants carry out regular antibiotic ward rounds to optimise antibiotic prescribing.

Infection prevention and control training is provided to clinical staff on a face to face basis allowing it to be interactive and ensure a good level of understanding.



MSSA (Meticillin sensitive Staphylococcus aureus) bacteraemia cases have remained static over the last four years although of note is the relatively low numbers. An internal target has been set to provide focus and to manage a reduction in MSSA cases in the Trust.

Initiatives will include screening of patients going for high risk surgery to ensure the MSSA is treated prior to surgery. All devices related MSSA bacteraemia cases are investigated and lessons learn to prevent further cases. This has prompted improvements in central line management.



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E.coli (Escherichia coli) bacteraemia cases are a great concern nationally and often associated with urinary tract infections. An internal target has been set to provide focus and manage a reduction in E.coli cases in the Trust. The Trust recognises that long term urinary catheters increase the risk of E.coli and has embarked on a project to reduce the number of long term catheters by providing alternatives where appropriate and improving the care of catheters that are required.

One of the initiatives has included a patient held record for patients discharged into community with catheters so they know how to look after their catheter and know when to seek help. This also provides a record for the nursing team to document when the next catheter change is due.

Cancer Waiting Times

Significant progress has been made in delivering important aspects of cancer services leading to falling mortality rates and consistent achievement of the cancer waiting times standards.

High quality and accurate data is key to improving services and therefore outcomes for patients, the Trust continues to be committed to supporting the Cancer Outcomes and Services Dataset (COSD).

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

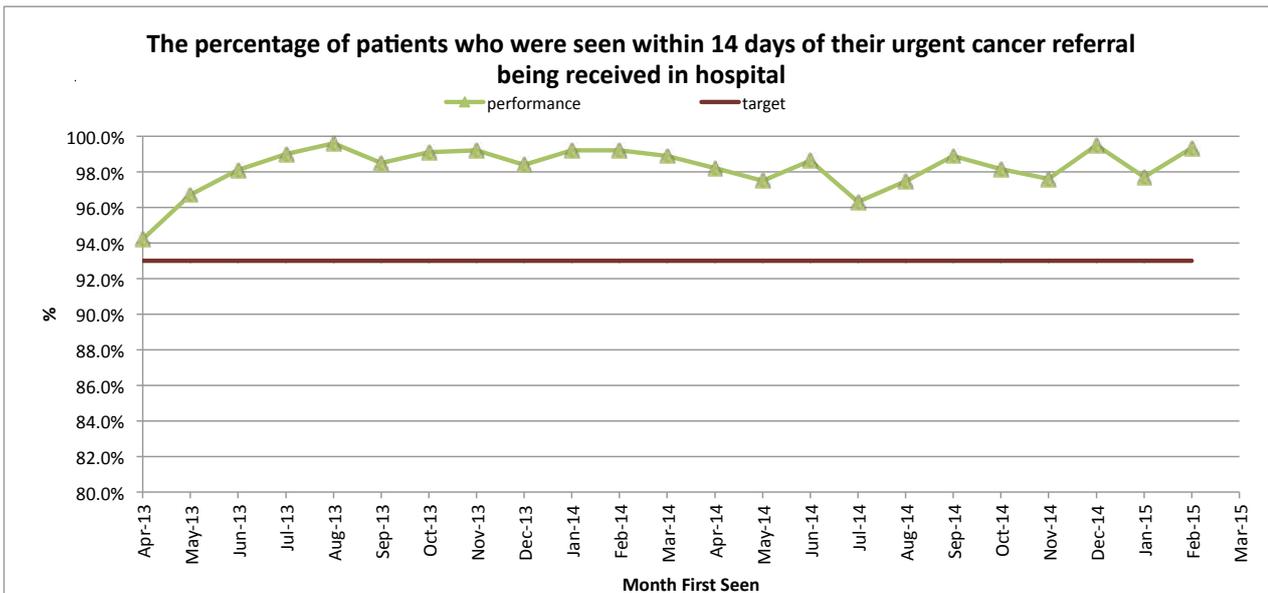


Chart 1 shows the Trust's reporting period April 2013 – March 2015 for patients seen within 14 days for urgent referral. The performance required for this target is 93% and this has been exceeded for the whole of the year.

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

- Patient choice of appointment date and time as a key driver for performance.
- The Trust has worked hard to review pathways so that patients can be seen within 7 days rather than 14.
- Within the network the Trust has made a significant achievement with this work.

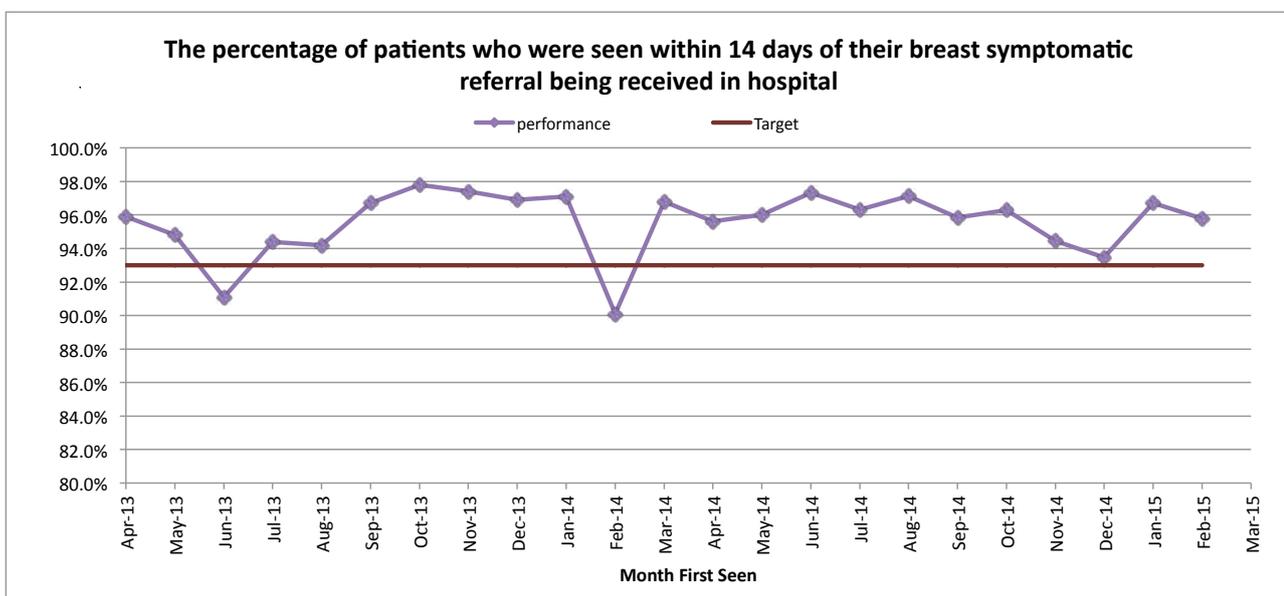


Chart 2 shows the percentage of patients who were seen within 14 days of their breast symptomatic referral being received in hospital for the reporting period April 2013 – March 2015.

The performance required for this target is 93%. Performance has been variable largely due to patients exercising choice about time and date of appointment.

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

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

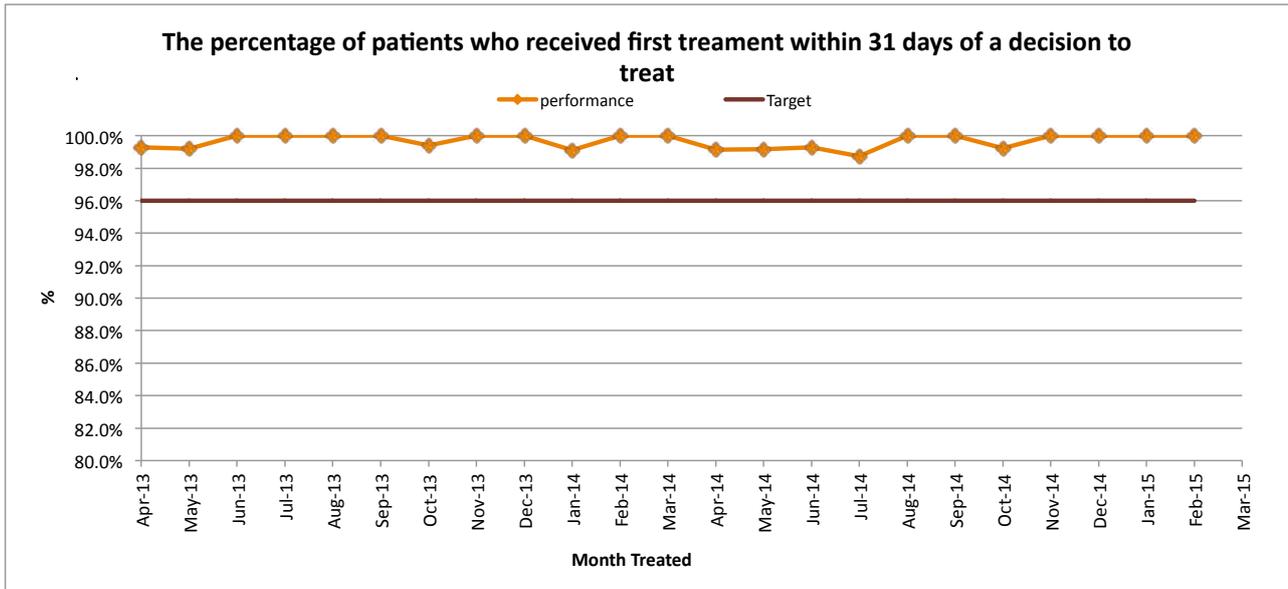


Chart 3 shows the percentage of patients who received first treatment within 31 days of a decision to treat for the reporting period April 2013 – March 2015.

The performance required for this target is 96%. Performance has largely been maintained at 100% with slight variations on four occasions; however this has not fallen below 99%.

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

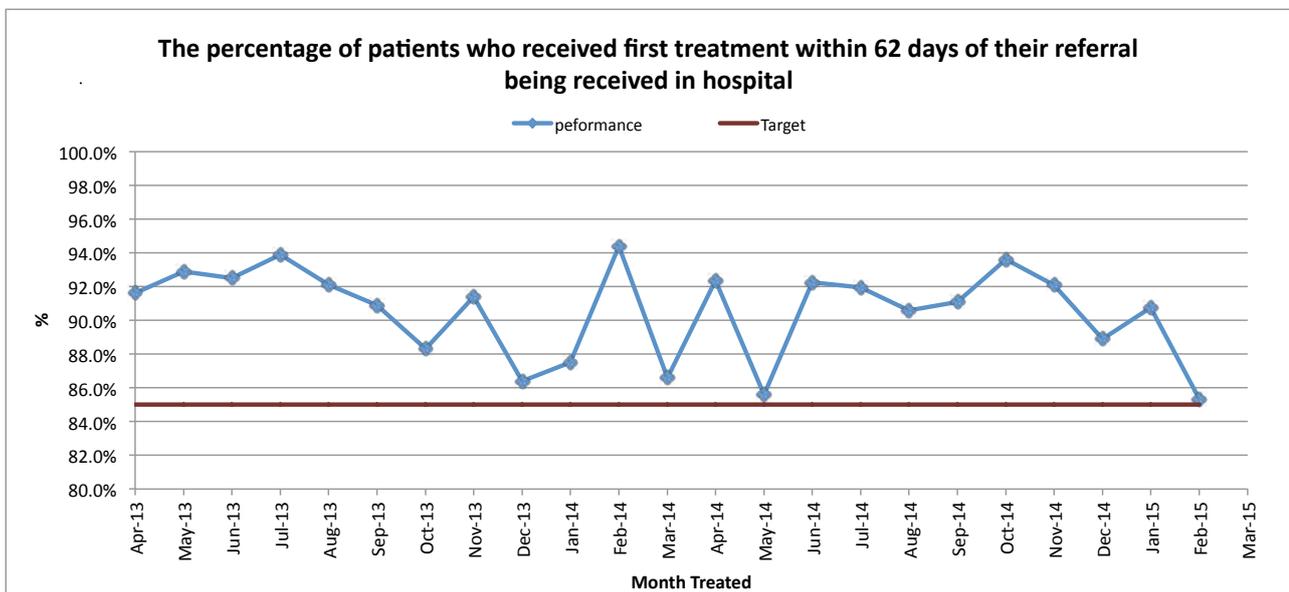


Chart 4 shows the percentage of patients who received first treatment within 62 days of their referral being received in hospital for the reporting period April 2013 – March 2015.

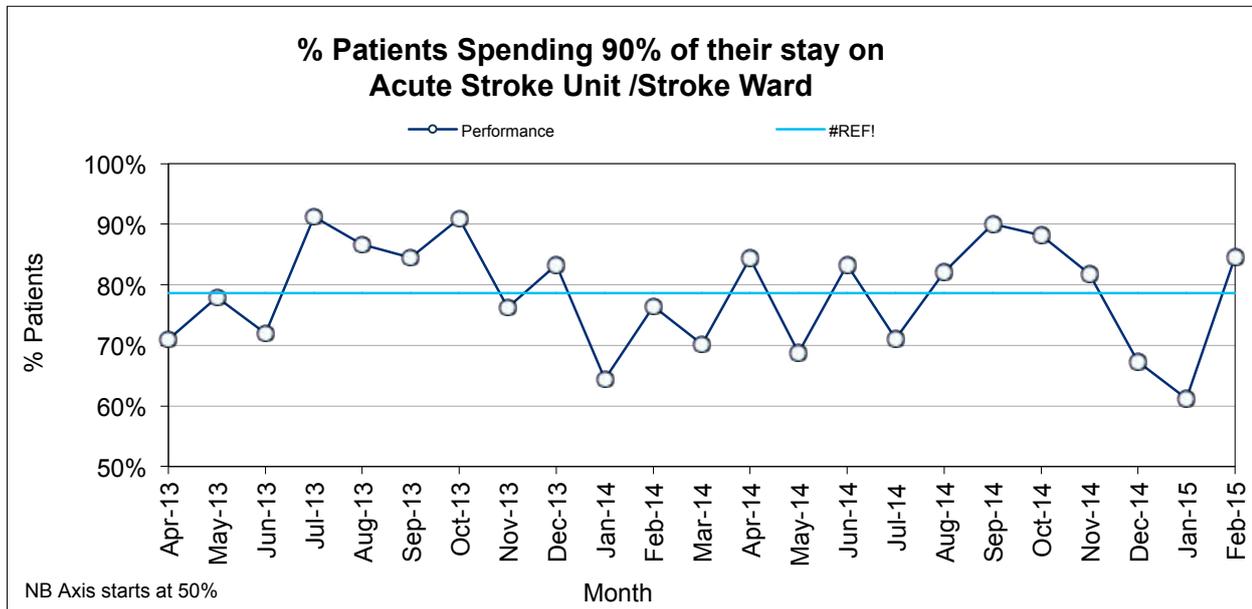
The performance required for this target is 85%. Performance has been above the required 85% for all of the year.

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

- Meet with all Clinicians to review pathways.
- Review of CT scan availability; reduce the diagnostic wait to 7 days.
- Working with primary care colleagues to review the diagnostic pathway.
- Continue to work with tertiary centres to improve handovers.
- Continue robust tracking of patients.

Stroke

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



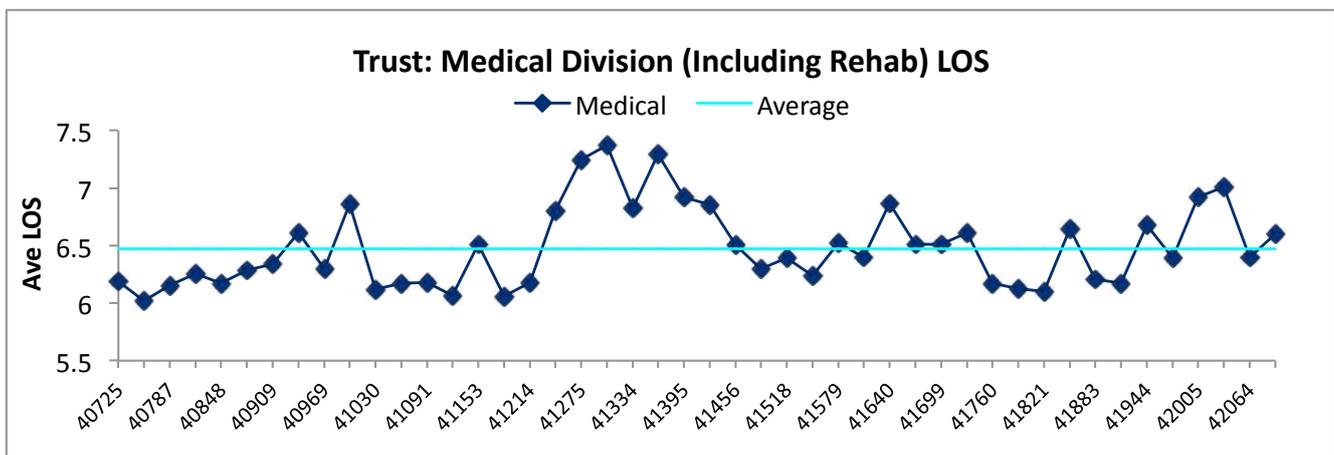
The above chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward.

Performance has remained variable throughout the year. Winter pressures in December and January explain the dip in compliance that occurred during these months.

There is a quality improvement work stream on Stroke. One of its key interventions is around improving this the time that patients stay on the specialised stroke ward along with other indicators from the sentinel stroke national audit programme such as therapy support, time to thrombolysis etc. All these indicators are closely monitored and compliance is reported in the Trust.

Length of stay in medicine

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



The chart above shows that the length of stay in medicine was relatively stable following the rise in early 2013; however since November 2014 it has started to rise again.

The primary reasons for the variation are seasonal pressures and an increased number of admissions. Analysis tells us that when patients are placed in beds in other specialities (because no beds are available in on the most appropriate ward) this increases length of stay. Seasonal pressure led to a rise in this practice and therefore a corresponding rise in length of stay.

Increased seasonal activity also increased pressure over the whole health economy, this increased delayed discharges due to lack of services in the community and further increased length of stay.

Work to address this is through the bed efficiency and length of stay programmes which are linked to the improving discharge planning priority in the quality account this year.

The length of stay and efficiency programmes are central work streams around planning bed stock for next winter to mitigate the need to place patients in other speciality beds and therefore reduce any seasonal variations.

Real time patient monitoring

The Trust has continued to operate a real time patient monitoring system, using volunteers to ask patients a set of pre-determined questions when they are ready for discharge. This allows the Trust to relate feedback to specific wards to drive improvement.

In previous years there has been a focus on improving doctors' communication, the data for 2014/15 demonstrates a continued high score for this indicator.

	2010/11	2011/12	2012/13	2013/14	2014/15*
When you have important questions to ask a doctor, do you get answers that you can understand?	8.0	8.3	8.9	9.3	9.3

- 11 months data only (April – February)

A series of questions assess whether patients know what is happening to them and whether they feel involved in decision making about their care and treatment. These have continued to score positively over the last 12 months.

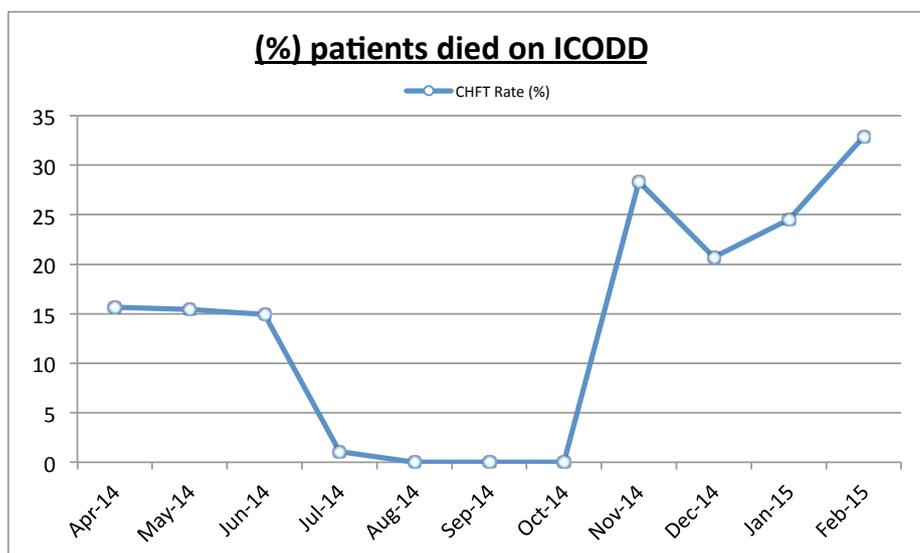
	2010/11	2011/12	2012/13	2013/14	2014/15*
Are you involved as much as you want to be in decisions about your care and treatment?	7.7	8.0	8.5	9.0	9.1
How much information about your condition or treatment has been given to you?	8.2	8.2	8.8	8.8	8.9
Before your operation or procedure, did a member of staff explain what would be done?	8.8	8.8	9.2	9.4	9.5
After the operation or procedure, did a member of staff explain how it had gone in a way you could understand?	7.9	8.2	8.6	8.8	8.7
Do you feel involved in decisions about your discharge from hospital?	7.3	8.5	8.8	9.2	9.4
Has a member of staff explained the purpose of the medicines you are to take at home in a way you could understand?	7.9	8.7	9.1	9.5	9.4
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	6.6	7.5	8.2	9.0	9.1

Whilst the Trust has received high scores for all of the above questions, a number of the comments we receive through real time patient monitoring and the Friends and Family Test suggests that there is still room for improvement. A project has therefore been designed with a focus on ensuring that patients / their family receive regular updates on their condition and treatment, based on 3 W's:

- What is the working diagnosis and plan for my patient?
- What do I need to communicate to other members of my clinical team (nursing staff, junior doctors, and staff in community)?
- What do I need to communicate to my patients and/or their families?

End of Life Care

The Trust continues to work to ensure that when patients die in hospital and their death is expected that they receive appropriate end of life care.



The above graph shows the percentage of patients dying who were supported by the individualised care of the dying document (ICODD). This document was implemented in the Trust at the beginning of November 2014 following consultation with staff from community and the hospices. It has received warm feedback from both families and clinicians.

The ICODD offers advice and guidance to staff and is focussed on the patient's individual needs at the end of life... Improving end of life care remains a priority area for the Trust, as well as the ICODD there are other interventions being introduced, for example comfort bags. These bags contain little essentials, such as bed socks, tissues, a dental kit, and a notebook and pen all aimed to ease time spent at a bedside if a relative needs to stay overnight.

Patient experience in accident & emergency

For the majority of unplanned patient attendances at hospital A&E is the first experience of care. As this is often a very stressful time it is important that the Trust understands and can improve on the service they receive.

Figure 1 - A&E RTM Comparison of Quarterly Results after Offset		National Survey 2012	2010/11 (Baseline)	2011/12	2012/13 (Only Q1 & Q2)	2013/14	2014/15
		Sample Size	338	583	549	239	428
Q1	Were you told how long you would have to wait to be examined?	3.2	4.3	8.2	6.5	#REF!	#REF!
Q2	Did the member of staff treating and assessing you introduce themselves?	N/A	N/A	N/A	7.9	#REF!	#REF!
Q3	Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.1	N/A	N/A	8.6	#REF!	#REF!
Q4	Did a doctor or nurse explain your condition and treatment in a way you could understand?	7.7	8.2	8.9	8.1	#REF!	#REF!
Q5	If you have an anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	N/A	N/A	N/A	#REF!	#REF!
Q6	How much information about your condition or treatment was given to you?	8.4	N/A	N/A	N/A	#REF!	#REF!
Q8	Do you think the hospital staff did everything they could to help control the pain?	6.9	8.3	8.8	7.6	#REF!	#REF!
Q9	If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.0	N/A	N/A	8.6	#REF!	#REF!
Q11	Did a member of staff explain the results of your tests in a way you could understand?	8.1	N/A	N/A	7.6	#REF!	#REF!
Q12	In your opinion, how clean was the A&E Department?	8.4	8.5	9.0	8.3	#REF!	#REF!
Q13	Were you able to get suitable food or drinks when you were in the A&E Department?	5.7	N/A	N/A	8.9	#REF!	#REF!
Q14	Overall, did you feel you were treated with respect and dignity while you were in the A&E Department?	8.8	9.5	9.7	9.2	#REF!	#REF!
Average Score		7.3	7.8	8.9	8.1	#REF!	#REF!
If the need arose, would you recommend this hospital to your family and friends? (Yes, definitely)		N/A	NA	NA	NA	85%	89%

The RTPM data is collected and reported quarterly in both A&E departments. It is mainly collected by volunteers as it is felt that A&E patients may feel more able to give an open response to a non staff member. However at the Calderdale site difficulty recruiting volunteers has meant that staff do supplement the data sets (although they do not work in the A&E department).

There has been a marked difference in patient experience scores across the two sites, both with questionnaire data and in friends and family feedback. As a result a specific action plan has been implemented at Huddersfield Royal Infirmary with many of the actions now complete. Patient experience groups are also meeting on both sites and include patient participation, to discuss areas of concern and to champion change.

To supplement the information further monthly data is also collected around 6 questions based on patient and staff experiences as part of the A&E quality improvement programme. The information is discussed monthly at the quality forum and in directorate management group so action can be taken where failings have been identified.

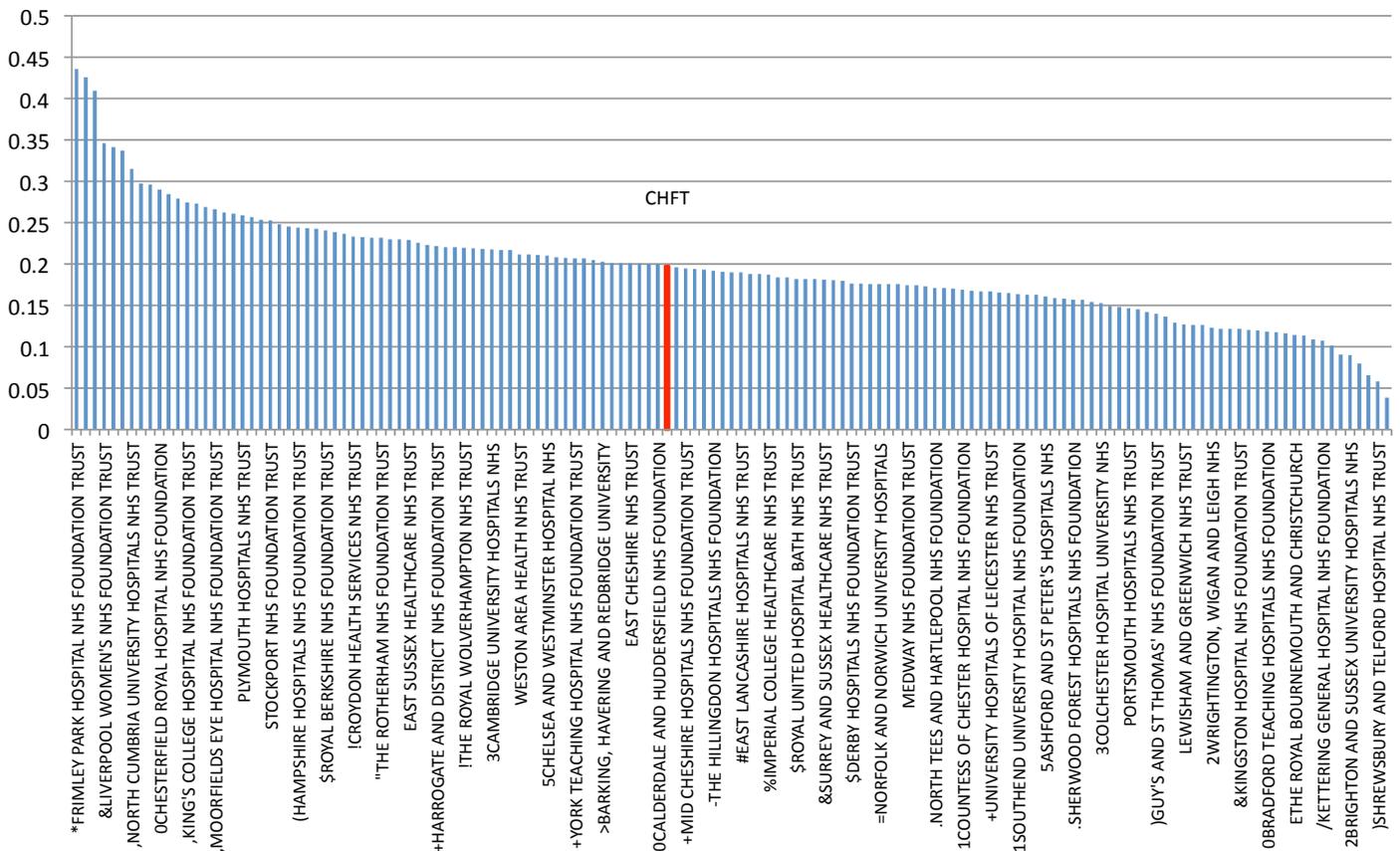
Friends and family in A&E

Another source of information is the friends and family test. The results are within the normal range but the response rate is however a challenge despite continual efforts to improve.

A lower target of 20% was set for the Accident & Emergency F&F response rate. This was achieved for the first 7 months of 2014/15; however this dropped to below 20% for subsequent months and can be directly attributed to a change in the method for capturing feedback. There was a shift from using tokens to using postcards based on national guidance that token collection systems (patients indicating their score by dropping a token into a box) were no longer permitted.

Over the 11 months a total of 88.7% of patients who responded said that they would recommend our care and 6.0% said they would not.

FFT A&E 2014-15 National Results **(Response Rate)**



Performance against relevant indicators and performance thresholds from the Risk Assessment Framework

Area	Indicator	Threshold	Performance	Achieved?
Access 1	Maximum time of 18 weeks from point of referral to treatment in aggregate-admitted	90%	91.4%	Yes
Access 2	Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted	95%	98.6%	Yes
Access 3	Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway	92%	94.5%	Yes
Access 4	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	95%	94.6%	No
Access 5	All cancers: 62-day wait for first treatment from:			
	● Urgent GP referral for suspected cancer	85%	91.0%	Yes
	● NHS Cancer Screening Service referral	90%	92.1%	Yes
Access 6	All cancers: 31-day wait for second or subsequent treatment , comprising:			
	● Surgery	94%	98.5%	Yes
	● Anti-cancer drug treatments	98%	100.0%	Yes
Access 7	All cancers: 31 day wait from diagnosis to first treatment	96%	99.6%	Yes
Access 8	Cancer: two week wait from referral to date first seen, comprising:			
	● all urgent referrals (cancer suspected)	93%	98.2%	Yes
	● for symptomatic breast patients (cancer not initially suspected)	93%	95.6%	Yes
Outcomes 16	Clostridium difficile – meeting the C. difficile objective	18	22	No
Outcome 20	Certification against compliance with requirements regarding access to health care for people with a learning disability	N/A	Yes	Yes
Outcome 21	Data completeness: community services, comprising:			
	● Referral to treatment information	50%	91.41%	Yes
	● Referral information	50%	98.32%	Yes
	● Treatment activity information	50%	98.57%	Yes

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Group

We were pleased to receive and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The following statement is presented on behalf of NHS Greater Huddersfield CCG and NHS Calderdale CCG. The Quality Account is a comprehensive assessment of the levels of quality and is consistent with the Commissioners understanding of quality in CHFT. It describes progress in many areas with comparisons against other hospitals and national targets which is helpful and demonstrates transparency. This statement will reference areas as CCGs we are pleased to see the progress made, and others where we feel the account could be strengthened.

We recognise a range of improvement work in relation to the identified priority areas for 2014/15, and welcome the improvement in incident reporting and complaints handling, which shows an open, transparent and listening culture. Your achievements in relation to reducing length of stay for patients with Diabetes, in particular, is to be commended, as is the evidence of greater autonomy for this group of patients. The account would be strengthened with inclusion of some narrative around sustainability of the improvement work, particularly in relation to the work to help patients with long term conditions to self-manage and how this will be rolled out to other areas.

We note that the information provided on readmissions is good, particularly for adults, and shows a significantly higher performance than average. However, we would have expected reference in the publication of nurse staffing levels, the work you are undertaking towards seven day working, and reference to safeguarding information in relation to adults or children. There are inconsistencies in the narrative on mortality indicators and sections on definitions are not clear for a lay person to understand.

The inclusion of the Care Quality Commission intelligence monitoring is good, along with the associated areas for improvement.

The identified priorities for 2015/16 of
I Improving Sepsis Care

- To ensure Intravenous antibiotics are given correctly and on time
- Improving the discharge process, and
- Better food

The rationale for why these have been chosen, the work to be carried out and what you are trying to achieve is clearly articulated and are recognised by commissioners.

We look forward to continuing to work closely with the Trust over the coming year in order support the Trust in achieving the quality improvement priorities set out in the account.

Dr Majid Azeb
Chair Calderdale CCG Quality Committee

Dr Judith Parker
Chair Greater Huddersfield CCG Quality and Safety Committee

Response from Healthwatch Kirklees

We have received no response from Healthwatch Kirklees, there is no requirement for them to comment.

Response from the Governors

We have received no responses from the Governors.

Response from Healthwatch Calderdale

Healthwatch Calderdale (HWC) notes that the Quality Accounts Report has been subject to audit. HWC has no significant anecdotal or soft evidence that would prompt doubt. We recognise the report as being an accurate reflection of CHFT performance.

HWC welcomes attempts to involve a wider public in the selection of action priorities. As the Members Council had participated in the process we would like to see their assessment of the outcomes included.

Although the priority of reducing the mortality rate has been partly met, HWC would like to see prominence given to the comparison with other similar hospitals. As "the SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected" we would urge highlighting of those areas and the actions taken to improve them.

The friends and family test is welcomed as is the Real Time monitoring by public & patient engagement - we note the high levels of satisfaction expressed.

The CQUINS achievements are not available in the draft versions, but we look forward to seeing them. If expressed as a % of the available amount, it would provide a useful indicator of the quality perceived by the commissioners.

Calderdale public have been extremely engaged about hospital reconfiguration especially around A&E services. The Quality Accounts Report does not clearly add to public knowledge by giving prominence to the relationship between the financial sustainability of the Trust, the quality of care it can provide, the safety of activity within the A&E departments and the pressures these make on a need for change.

The report is complex and is not a friendly document for general public use. HWC recognise that the report has been prepared for widely different readerships and has to conform to some specifications, but we would like to see a consistent display of how the measured parameters compare with other Trusts and have an easy read summary incorporated. Presentation of the facts in a more easily comprehensible manner would be a clear expression of recognition regarding the public's needs and would display a culture of openness.

Mr Tony Wilkinson
Chair of Healthwatch Calderdale

Response from Calderdale Overview and scrutiny Committee

Much of our time in Adults Health and Social Care Scrutiny Panel meetings this month has been spent on the implications of any hospital reconfiguration for Calderdale residents. This has meant that the Scrutiny Panel (as well as the Council's People's Commission and the Calderdale and Huddersfield Joint Health Scrutiny Committee) has paid considerable attention to the medium and long term strategic plans for hospital care and less on some of the detail contained in your Quality Plan. I hope that next year we can include some time at the Scrutiny Panel on more of the detail of the services provided by your Trust, as well as the long term future for the Trust which will inevitably take much of our attention. I think there would be merit in the Scrutiny Panel devoting one meeting to discussing quality of service issues with you (perhaps holding the meeting at Calderdale Royal Hospital if that is possible) and I will ask Mike Lodge to contact Catherine Riley to arrange that.

It is pleasing to see some progress against your priorities for 2014/5. However, mortality rates remain above national averages and I would welcome some discussion of this at a Panel meeting over the coming year. One of Sir Robert Francis' comments about overview and scrutiny in Staffordshire was, "[they] showed a remarkable lack of concern or even interest in the [mortality] data. Difficult though statistics can be to understand, it should have been possible to grasp that they could have meant there was an excess mortality that required at least monitoring by the committee". I feel that we have not given this issue sufficient attention despite the clear message from Sir Robert and I think this should be rectified in the coming year.

It is perhaps inevitable that the Quality Account should focus on hospital services. However, it is difficult to identify which of your Priorities for last year or the coming year have some application to those community health services that you provide. Improvements in community health services have been presented to the Scrutiny Panel as a key way of suppressing demand for acute hospital care and hence influencing any reconfiguration of hospital services. I am sure the Panel will be interested in your assessment of progress in changes to community health services that you provide and we will build that into our schedule for 2015/16.

I would like to comment particularly on your new priority of improving the discharge process. Delayed discharge continues to be reported above target levels and, as you indicate in the Quality Account the local authorities and other care providers have a part to play in helping improve this situation. I hope that the Better Care Fund will contribute to achieving improvements in this area. I am sure that the Scrutiny Panel will want to ensure that all partners are playing their part to ensure that patients get the right outcomes and the best experience when they are discharged from hospital.

It is understood that there is frequently a difference of view between CHFT and AHSC regarding the responsibility for the delay in patients leaving hospital. This is regarded as a major cost point to CHFT and several approaches are proposed to improve the position. The Scrutiny Panel will wish to explore this in considerable detail next year with a view to establishing the causes and results of the so called "bed blocking".

Our Scrutiny Panel and the Calderdale and Kirklees Joint Health Scrutiny Panel will inevitably be heavily involved in assessing the impact of any proposals that Calderdale Clinical Commissioning Group and Greater Huddersfield Clinical Commissioning Group make about the provision of acute hospital care. Our priority next year will be to ensure that high quality easily accessible hospital care is available for all Calderdale residents and I look forward to working with you on that over the coming year.

Councillor Malcolm James
Chair, Adults Health and Social Care Scrutiny Panel

Response from the Well-Being and Communities Scrutiny Panel in Kirklees Council

Thank you for the letter dated 17 April 2015 inviting comment from the Well-Being & Communities Scrutiny Panel in Kirklees Council on the draft 2014/15 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

The comment from the Panel for publication is detailed below:

The Kirklees Council Well-Being & Communities Scrutiny Panel, as the local health overview and scrutiny committee, has reviewed the Draft Quality Account which included reference to the Department of Health's guidance for Overview and Scrutiny Committees.

The Panel has noted your priorities for 2015/16 and is generally supportive of the range of areas that they will cover although there were a number of areas that it felt warranted further comment.

The Panel welcomed the priority for improving sepsis care and noted that the Yorkshire Ambulance Service had also highlighted this issue and included it as a priority for 2015/16. The Panel did however feel that the domain for this priority should have been classed as an effectiveness criterion and that it would be helpful to include an explanation of the differences in the domains that are used by the Trust to categorise the priorities.

The Panel also welcomed the continued focus on intravenous antibiotics and look forward to seeing further progress during 2015/16. However the Panel did note the rise in missed doses during the winter months 2013/14 and felt that it would have been prudent to include an additional objective for 2015/16 designed to improve performance during the next winter period.

The Panel was pleased that work will be done to improve the discharge process and keep patients better informed about their care arrangements. During 2014/15 the Panel has maintained a close focus on the work that is being done to enhance and strengthen community based healthcare services across Calderdale and Kirklees. The integration of health and social services is a key element of these changes and will have a significant impact on the Trust's objective of reducing delays in discharge from hospital. For this reason the Panel felt that it would have been sensible to reference this work and outline the approach the Trust is taking to support these developments.

The Panel acknowledged the importance of patients receiving appetising and nutritionally balanced food and the contribution it can make to the wellbeing of a patient. However the Panel felt that the target of improvements in patient satisfaction was unambitious and believed that the target could have been strengthened by including specific objectives in terms of the food offering in order to demonstrate progress in the provision of a wider range of nutritious and healthier food options and in the choice of food selected by the patient.

The Panel noted that the Trust's Hospital Standardised Mortality Rates are still above the national average and although the Panel acknowledged that the 2015/16 focus on sepsis and the administration of IV antibiotics will have an impact on this issue the Panel felt that it would have been sensible to continue to include this as a priority for 2015/16.

The Panel also noted that the number of patient falls in the hospital continued to be the highest reported safety incident in the Trust and although the Panel acknowledged that work was taking place to address this issue the Panel was surprised that hospital falls wasn't included as one of the priorities for 2015/16.

During 2014/15 the Panel considered and reviewed a number of areas that it felt were of local importance. This included: looking at the Trust's plans to achieve financial savings through its balanced plan; reviewing the work being done to improve the quality of care provided to patients through the Care of the Acutely Ill Patient Programme; challenges related to staff shortages in key areas such as nursing and A&E; the impact that the increased demand during the winter period had on A&E; and the work that is taking place to develop proposals for changes to hospital services.

Given the local interest in these matters and the potential impact on health services in the district the Panel felt that it would have been appropriate for the Trust to have made reference to these issues in the document.

The Panel felt that the report did highlight the work of the trust to engage with staff, patients and the public and noted the importance that the Trust placed on using information from a variety of sources such as clinical data and patient feedback to help improve the quality and safety of care provided to patients.

In addition to the above statement for inclusion in the report, the Panel would also like to make the additional comments regarding the content and format of the report:

- General – The Panel accept the need to use medical terminology and acronyms but believe that most people reading the account would find it difficult to fully comprehend the information and for this reason the Panel would recommend that you refer to and include a glossary of terms in the document.
- General – Although the Panel noted that a statement from the Chief Executive will be added the Panel felt that it would have been helpful to have included an executive summary that would provide an explanation of what the document is intended to convey. The Panel also believed that a contents page would be useful.

- General – The Panel accept that the use of graphs can be a useful way to present data/information however the Panel found a number of the charts difficult to interpret (Particularly those graphs that showed a number of different fields/data) and some of the charts/graphs were too small and difficult to read.
- Final data relating to the CQUIN payment framework is missing which means that the Panel is unable to fully comment on this aspect of the Quality Account.
- SHMI Trend – The Panel felt that it would be helpful to provide an explanation for those periods that show a higher risk (concern); and the Trust's position when compared against other acute NHS providers.
- The Panel noted that the numbers of patient's deaths with palliative coding has varied considerably from the national rate. The Panel support the approach to monitor closely the use of palliative care coding but felt that taking account of the information the trust has collated it would be helpful to include an explanation on why there is such a variance in the data.

Richard Dunne
Principal Governance and Democratic Engagement Officer
On behalf of the Well-Being & Communities Scrutiny Panel

Statement of directors' responsibilities for the quality report

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

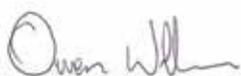
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2014 to 28 May 2015
 - papers relating to Quality reported to the board over the period April 2014 to 28 May 2015
 - feedback from commissioners dated 08/05/2015
 - feedback from governors dated – not received
 - feedback from local Healthwatch organisations dated 28/04/2015
 - feedback from Overview and Scrutiny Committee dated 05/05/2015 and 08/05/2015
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX
 - the latest national patient survey 21/05/2015
 - the latest national staff survey February 2015
 - the Head of Internal Audit's annual opinion over the trust's control environment dated 28 May 2015
 - CQC Intelligent Monitoring Report dated May 2015
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor.gov.uk/annualreportingmanual).

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

By order of the Board of Directors



Owen Williams
Chief Executive
28 May 2015



Andrew Haigh
Chief Executive



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

We have been engaged by the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicator for the year ended 31 March 2015 subject to limited assurance is:

- emergency re-admissions within 28 days of discharge from hospital

We refer to this national priority indicator as "the indicator" ..

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

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

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

- board minutes for the period April 2014 to the date of signing of the limited assurance opinion
- papers relating to quality reported to the board over the period April 2014 to the date of signing of the limited assurance opinion
- feedback from Commissioners, dated 08/05/2015
- feedback from local Healthwatch organisations, dated 28/04/2015
- feedback from Overview and Scrutiny Committee dated 05/05/2015
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 28/05/2015,
- the [latest] national patient survey, dated 21/05/2015.
- the 2014 national staff survey
- Care Quality Commission Intelligent Monitoring Reports, dated July 2014 and October 2014; and
- the Head of Internal Audit's annual opinion over the trust's control environment, dated April 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Calderdale and Huddersfield NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- testing key management controls
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report.
- reading the documents.

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

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

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

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

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP
Chartered Accountants
1 St Peter Square
Manchester
M2 3AE

The independent auditors reviewed three indicators this year, 18 weeks, 28 day readmissions and average length of stay. One was selected by Monitor and the other two by the Trust. The mandatory indicator selected by monitor was the 18 week indicator. We haven't received the final report from the auditors but we are aware that they will be unable to provide us with assurance against this indicator. This is due to there being six patients of the 23 that were audited where there were errors in the way the individual patients had been coded. We had coded them as breaches but the auditors have confirmed that they weren't likely to have been breaches. Action is being taken to look at the causes of this and changes will be made to resolve the issue. The other two indicators we believe will be assessed as compliant with the reporting rules for those indicators.

Appendix A

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in/participated in for which data collection was completed during 2014/15, are listed below. The numbers of cases submitted to each audit or enquiry as a percentage of the number of registered cases required (by the terms of that audit or enquiry) are also listed.

Women's and Children's Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases Submitted
Child health programme (CHR-UK)	No	NA	-	-
Epilepsy 12 audit (Childhood Epilepsy)	Yes	Yes	All	Continuous – all cases ongoing
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	484	100%
Paediatric intensive care (PICANet)	No	NA	-	-
CEM Audit – fitting child	Yes	Yes	On-going	On-going

Acute

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases Submitted
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%	On-going
National Joint Registry (NJR)	Yes	Yes	967	On-going
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	130	100%
CEM Audit Older People	Yes	Yes	On-going	On-going
CEM Audit Mental Health	NA	NA	-	-
BTS Adult Community Acquired Pneumonia	Yes	Yes	On-going	On-going
BTS National Plural Procedures	Yes	Yes	16	100%
BTS Adult NIV Audit	Yes	Yes	On-going	On-going

Blood and transplant

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA: 2014 Audit of transfusion in children and adults with Sickle Cell Disease	Yes	Yes	On-going	All cases to be submitted

Cancer

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Bowel cancer (NBOCAP)	Yes	Yes	249	100%
Head and neck oncology (DAHNO)	No	N/A	-	-
Lung cancer (NLCA)	Yes	Yes	100%	All cases in time period
Oesophago-gastric cancer (NAOGC)	Yes	Yes	100%	On-going
National Prostate Cancer Audit	Yes	No	-	-

Heart

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	Yes	100%	100%
Adult cardiac surgery audit (ACS)	No	N/A	-	-
Cardiac arrhythmia (HRM)	Yes	Yes	100%	On-going
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	-	-
Coronary angioplasty	Yes	Yes	475	100%
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	196	31%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	53	On-going

Long term conditions

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	On-going	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD)	Yes	Yes	31	All cases in time period
Renal replacement therapy (Renal Registry)	No	N/A	-	-
National COPD Audit BTS	Yes	Yes	257	100%
National Diabetes Foot Care Audit	Yes	Yes	On-going	On-going
National Audit of Standards for Ulnar Neuropathy at the Elbow (UNE) testing	Yes	Yes	20	100%

Mental Health

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Prescribing for substance misuse: Alcohol detoxification	No	N/A	-	-
Prescribing for bipolar disorder (use of sodium valproate)	No	N/A	-	--
Prescribing for ADHD in children, adults and adolescents	No	N/A	-	-

Older People

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Falls and fragility fractures audit programme	Yes	N/A	-	-
Sentinel Stroke (SSNAP)	Yes	Yes	All	On-going
Rheumatoid and early inflammatory arthritis (NCAPOP)	Yes	Yes	All	On-going
National Audit of Intermediate Care	Yes	Yes	All	All cases in time period

Other

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Elective surgery (National PROMs Programme)				
Groin hernia	Yes	Yes	173	On-going
Hip replacements	Yes	Yes	252	On-going
Knee replacements	Yes	Yes	202	On-going
Varicose veins	Yes	Yes	131	On-going

National Confidential Enquiries

Audit title	Trust Eligible for Involvement	Trust Participated	Audit Sample	% Cases submitted
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:				
Gastrointestinal Haemorrhage	Yes	Yes	9	88%
Lower limb amputation study	Yes	Yes	7	86%
Tracheostomy study	Yes	Yes	2	100%
Sepsis Study	Yes	Yes	10	90%

The national clinical audits and national confidential enquiries that the Trust did not participate in and reasons during 2014/15 are as follows:

- The Trust didn't participate in the National Prostate Cancer Audit due to unsupported IT systems.

The reports of 25 national clinical audits were reviewed by the provider in 2014/15 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

National audit of inflammatory bowel disease (IBD) service provision

The UK National IBD Audit aims to improve the quality and safety of care for IBD patients throughout the UK, by involving professional groups and patients in a national audit of individual patient care and of service resources and organisation in all hospitals

The project is based on a collaborative working partnership between the British Society of Gastroenterology, the Association of Coloproctology of Great Britain and Ireland, the National Association of Colitis and Crohn's Disease and the Royal College of Physicians' Clinical Effectiveness and Evaluation Unit.

Objectives:

The aim of the national IBD audit (round 4) (2012–14) has seen substantial changes to methodology, with the prospective collection of data for up to 50 patients with ulcerative colitis per site and the adoption of the IBD quality improvement project (IBDQIP) tool for the assessment of organisation of services and to drive quality improvement. The audit has assessed patient outcomes more thoroughly in terms of disease activity, quality of life, patient-reported outcome measures and patient experience.

The report examines the quality of adult IBD services throughout the UK. Participating services were asked to report the status of their own service as at 31 December 2013. The quality of a service is assessed against the Standards for the healthcare of people who have inflammatory bowel disease:

- Standard A – High Quality Clinical Care
- Standard B – Local Delivery of Care
- Standard C – Maintaining a Patient- Centred Service
- Standard D – Patient Education and Support
- Standard E – Data, Information Technology and Audit
- Standard F – Evidence-Based Practice and Research

What changes in practice have been agreed?

- Setting up of IBD MDT to meet on a monthly basis
- To establish a monitoring tool
- Recruitment of an additional Gastroenterologist Consultant

CEM – Severe sepsis and septic shock (adults)

The College clinical standards for severe sepsis and septic shock were first published in May 2009. The standards are based on the 'Sepsis Six' published by the Surviving Sepsis Campaign. A national audit of the standards was undertaken for the first time in 2011/12. Following the audit the College standards were revised in August 2012.

The purpose of the audit is to identify current performance in Emergency Department (EDs) against CEM clinical standards on the recognition and management of adults with severe sepsis or septic shock and show the results in comparison with other departments.

The standards are as follows:

1. Temperature, pulse rate, respiratory rate, blood pressure, oxygen saturation, mental status (AVPU or GCS) and capillary blood glucose within 15 minutes of arrival
2. Senior EM assessment of patient within 60mins of arrival
3. High flow O2 via non-re-breathe mask was initiated (unless there is a documented reason to the contrary) before leaving the ED
4. Serum lactate measured before leaving the ED
5. Blood cultures obtained before leaving the ED
6. Fluids - first intravenous crystalloid fluid bolus (up to 20mls/kg) given:
 - 75% within 1 hour of arrival
 - 100% before leaving the ED
7. Antibiotics administered
 - 50% within 1 hour of arrival
 - 100% before leaving the ED
8. Urine output measurements instituted before leaving the ED.

A departmental drive to improve practice and meet the 1 hour target was put into effect immediately. A repeat audit of 50 patients was undertaken April/May 2014. The results showed an improvement. 36% of patients received antibiotics within an hour.

Other National Clinical Audits the Trust has participated in during 2014/15:

- Breast cancer clinical outcome measures project - National Audit Symptomatic Breast Cancer
- National Breast Screening Programme
- UK National Bariatric Surgery Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Mid-Urethral Tapes (BAUS)
- Nephrectomy Surgery (BAUS)
- PCNL (BAUS)
- Invasive cytology
- British Association for Sexual Health and HIV and British HIV Association
- National Cardiac Rehab audit
- National review of adult asthma deaths – year 3
- National care of the dying – round 4
- British Society of Urogynaecology National Audit on Stress Incontinence
- Audit on Preventing early onset neonatal group B streptococcal disease
- Autoimmune Hepatitis
- SAMBA (Day in the life of an AMU)
- National Transition and DKA Audit
- NAP 5: Accidental Awareness during General Anaesthesia (AAGA)
- Sprint National Anaesthesia Project SNAP 1
- APRICOT (Anaesthesia Practice in Children Observational Trial)
- National Completed Acute Diverticulitis Audit (CADS)
- RCR National Emergency CT reporting audit

The reports of 80 local clinical audits were reviewed by the provider in 2014/15 and the Trust intends to take the following actions to improve the quality of healthcare provided:

New onset angina clinic (rapid access chest pain clinics)

The new onset angina clinic (rapid access chest pain clinics) is new service for CRH. It provides a quick and early specialist cardiology assessment for patients with new onset of exertion chest pain thought likely to be angina, and for patients not currently under a cardiologist who have known ischaemic heart disease and worsening symptoms and who need urgent assessment. This is a consultant-led, one-stop clinic, which enables a rapid and definitive assessment of symptoms and investigations and results in either the initiation of treatment or the swift reassurance of patients without pathology and at the moment are run 3 times a week

All patients are seen within two weeks of a referral, with results sent by fax within 24hrs. The clinic is a fast route of entry for patients into cardiology services. It allows quick access to appropriate treatment, either medication or invasive procedures and to all-important risk factor modification, prevention and rehabilitation services. It accepts referrals of patients with new onset chest pain suspected to be cardiac in origin. Patients with known ischaemic heart disease are referred to the general cardiology clinic unless they have worsening symptoms.

The audit was undertaken to review referrals to the new onset angina clinic in CRH in the first 12 months of the service using NICE CG95: Managing new onset angina.

Of the total number of 810 patients who were referred, only 133 were inappropriate (16%). The majority of patients (82%) were referred from primary care. 11% of patients had no chest pain and 30% were followed up in the cardiology clinic. The majority of patients had low probability of IHD (71% are < 30%).

The new onset angina clinic is working well. New standards for the new onset angina clinic acceptance forms have been set thereby working towards more efficient clinics.

Consultants will refer to the Heart Failure Nurse, and the Acute Coronary Syndrome nurse aids the cardiology non-invasive team lead with clinical decisions.

Re-audit of Gentamicin levels following change of dosing regime to comply with NICE CG149: Antibiotics and Early Onset of Neonatal Infection

Gentamicin is a broad spectrum aminoglycoside antibiotic that is widely used as the first choice antibiotic for the treatment of neonatal infection.

NHS organisations, clinical directors and those responsible for the provision of neonatal services have to ensure that compliance with the care bundle is measured daily for each patient in the sample group until full compliance for all patients receiving gentamicin is achieved.

As recommended in the March 2014 audit, a new prescription chart was introduced in August 2014, following approval from the Medicines Management Committee. This was to ensure compliance with NICE guidelines in the prescribing and administration of gentamicin.

The audit was undertaken to ensure improvement of compliance of gentamicin levels in accordance with the NICE guidance and to check that levels of gentamicin have improved since introduction of new prescription chart. 71 samples (10 post dose & 61 pre-dose) of gentamicin levels were checked in the period August to October 2014. Samples were taken from NNU and postnatal wards at CRH.

Findings were:

- The number of post dose levels has reduced significantly. Only 10 post dose levels were done in this period, according to previous criteria about 60 post dose levels would have been done in the same period of time.
- The post dose levels done have a higher mean level now suggesting that a better therapeutic range is being achieved overall.
- Pre dose gentamicin levels have improved, previously up to 20% of levels in the smallest babies had been too high, increasing the risk of toxicity, and this proportion overall has dropped to 4.7%.
- The proportion of levels below the lower cut off range has decreased and the proportion of levels above the upper cut off range of 12 has increased but none of the levels done were significantly too high.

The new Gentamicin dosing regime seems to be working well apart from occasional problems with inappropriate post gentamicin levels being taken.

Actions:

- The aim is to set up a real time monitoring system of Gentamicin levels to ensure these are now within the satisfactory range following the recent changes made. An alert box will be added to PAS to remind requesters of the criteria for checking post dose levels. Microbiology / IT have agreed to put an alert on the system.
- Need to promote the indications for post gentamicin levels being taken, including on the postnatal wards
- Re-audit in 2015-16.



Remuneration and Nomination Committees

Andrew Haigh, Chair of the Remuneration and Nominations Committees

Remuneration Committees

There are two committees which deal with the Remuneration of the Board of Directors. The Remuneration and Terms of Service Committee is a sub-committee of the Membership Council and deals with the remuneration for the Chair and Non-Executive Directors. The Remuneration Committee comprising Non-Executive Directors deals with the remuneration made to Executive Directors. The Committees receive advice from the Executive Director of Workforce and Organisational Development and are able to seek other professional and legal advice where required.

Remuneration of Non-Executive Directors

The Remuneration and Terms of Service Committee met on the 27 January 2015 and:

- Reviewed and agreed their terms of reference, having regard to the Association of NHS Providers 'Good Governance' with the amendment to the quoracy from 4 to 3.
- Reviewed and agreed the existing Terms and Conditions of Service.
- In line with the pay decisions for the NHS workforce in 2014-15, the proposal for the Non- Executive Directors to maintain their current levels of basic remuneration and receive no uplift was agreed.

The sub committee for the remuneration of Non-Executive Directors during 2014/15 comprised of:-

NAME AND ROLE	ATTENDANCE AT MEETING ON 27 JANUARY 2015
Rev Wayne Clarke, Publicly Elected Member (Chair)	✓
Mrs Chris Bentley, Staff Elected Member	✓
Mrs Eileen Hamer, Staff Elected Member	✓
Mr George Richardson, Publicly Elected Member	✓
Mrs Jennifer Beaumont, Publicly Elected Member	✗
Mrs Dawn Stephenson, Nominated Stakeholder	✗

Remuneration of Executive Directors

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

During 2014/15 the Committee met on three occasions. It reviewed its Terms of Reference and, having regard to the Association of NHS Providers 'Good Governance' in accordance with the Committee's Terms of Reference it was agreed that:

- To accept the Local Senior Manager pay scales as the base pay position for Directors.
- In this financial year 2014/15, in accordance with the national position on pay for NHS staff and having regard to the Trust's financial position, it was agreed that there is no pay uplift to any of the Directors individual remuneration or Local Senior Manager pay scales.
- The Executive Director of Nursing should also take on the role of Deputy Chief Executive and Director of Operations with effect from 1 November 2014.

The membership of the Remuneration Committee for Executive Directors during 2014/15 is set out below. The Non-Executive Chair of the Audit and Risk Committee does not sit on the Remuneration Committee for Executive Directors to ensure good governance:

NAME & ROLE	26 JUNE 2014	30 OCTOBER 2014	26 FEBRUARY 2015
Mr Andrew Haigh, Chair	✓	✓	✓
Dr David Anderson, Non-Executive Director	✗	✓	✓
Mr Philip Oldfield, Non-Executive Director	✓	✓	✓
Dr Linda Patterson, Non-Executive Director	✓	✓	✓
Mr Jeremy Pease, Non-Executive Director	✓	✓	✓
Mrs Jan Wilson, Non-Executive Director	✓	✓	✓

Nomination Committees

There are two committees who deal with Nominations to the Board of Directors. The Nominations sub-committee of the Membership Council deals with the nomination of the Chair and Non-Executive Directors. The Nomination Committee for Executive Directors comprises Non-Executive Directors and deals with the nomination of Executive Directors.

All members of the Board of Directors sit on the Nominations Committee for Executive Directors. During 2014/15 the Board met as a Nominations Committee on the 29 January 2015. At this meeting the Committee reviewed the Terms of Reference and approved the appointment of Dr David Birkenhead to the substantive post of Medical Director with immediate effect on a permanent basis.

Attendance at this meeting was:

NAME AND ROLE	29 JANUARY 2015
Andrew Haigh, Chairman	✓
Dr David Anderson Non-Executive Director	✓
Julie Dawes, Executive Director of Nursing and Operations	✓
Keith Griffiths, Executive Director of Finance	✓
Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities	✓
Julie Hull, Executive Director of Workforce and Organisational Development	✓
Jeremy Pease, Non-Executive Director	✓
Dr Linda Patterson, Non-Executive Director	✓
Owen Williams, Chief Executive	✓
Jan Wilson, Non-Executive Director	✓
Prof. Peter Roberts, Non-Executive Director	✗
Mr Philip Oldfield, Non-Executive Director	✗

Non-Executive Nomination Committee

The Nomination Committee did not convene during 2014/15 due to there being no tenures or vacancies to consider. The Committee membership is:

Mr Martin Urmston, Publicly Elected Member
Johanna Turner, Publicly Elected Member
John Playle, Nominated Stakeholder Member
Linda Wild, Publicly Elected Member

The Chair of the Board is also required to disclose any other significant commitments to the Membership Council. The Chair did not have any other significant commitments to disclose during 2014/15.

Remuneration Report

I am pleased to present the Remuneration Report for 2014/15. At Calderdale and Huddersfield NHS Foundation Trust we recognise that our remuneration policy is important to ensure that we can attract and retain skilled and experienced leaders that are able to deliver our ambitious plans for delivering compassionate care. At the same time it is important to recognise the broader economic environment and the need to ensure we deliver value for money.

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

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

Details of the membership of the Remuneration Committee and individual attendance can be found on p120 of this report.

Remuneration Policy

The Trust's remuneration policy applies equally to Non-Executive Directors, Executive Directors and senior below Board level posts and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people. When setting levels of remuneration, the Committee also takes into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. The Committees also receive professional reports derived from the Annual Reports of all Trusts of a similar size and complexity as Calderdale and Huddersfield NHS Foundation Trust (the annual IDS NHS Boardroom Pay Report). The way in which the Committees operate is subject to audit scrutiny.

The Trust has well established performance management arrangements and each year I undertake an appraisal for each of the executives and I am appraised by the Chairman. We do not have a system of performance-related pay and therefore in any discussion on remuneration an individual's performance is considered alongside the performance of the executive team and the organisation as a whole.

The executive directors are employed on permanent contracts with a 6 month notice period. In any event where a contract is terminated without the executive receiving full notice, compensation would be limited to the payment of the salary for the contractual notice period. There would be no provision for any additional benefit over and above standard pension arrangements in the event of early retirement. Non-executive directors are requested to provide 6 months' notice should they wish to resign before the end of their tenure. They are not entitled to any compensation for early termination. The Trust has no additional service contract obligations.

Off-payroll arrangements

As part of the remuneration report, we are required to present the following for our highly paid and / or senior pay-roll engagements:

Table 1: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last longer than six months

Number of existing engagements as of 31 March 2015	1
Of which.....	
Number that have existed for less than one year at time of reporting	1

All our payroll engagements are subject to a risk-based assessment and where considered necessary, we seek assurance as to whether the individual is paying the right amount of tax.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	1
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	0
Number for whom assurance has been requested	0
Of which.....	
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

The Trust is continuing to work with agencies to ensure contractual clauses are in place. The engagement for which assurance had not been received has since ended.

Table 3: For any off-payroll engagements of board members and / or senior officials with significant financial responsibility, between 1 April 2014 and March 2015

Number of off-payroll engagements of board members, and / or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and / or senior officials with significant financial responsibility' during the financial year. This figure should include both off-payroll and on-payroll engagements.	6

Exit packages

There were no exit packages paid for executives during 2014/15.

Salary and pension contributions of all executive and non-executive directors

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

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

Name and Title		2014-15						
Salary	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonus	Pension Related Benefits	Total			
(bands of £5,000) £000	(bands of £00) £000	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000			
50 - 55	0	0	0	0	50 - 55			
10 - 15	0	0	0	0	10 - 15			
10 - 15	0	0	0	0	10 - 15			
15 - 20	0	0	0	0	15 - 20			
10 - 15	0	0	0	0	10 - 15			
10 - 15	0	0	0	0	10 - 15			
15 - 20	0	0	0	0	15 - 20			
65 - 70	0	0	0	0	65 - 70			
145 - 150	0	0	0	0	145 - 150			
130 - 135	0	0	0	5.0 - 7.5	140 - 145			
125 - 130	0	0	0	0	125 - 130			
180 - 185	0	0	0	40 - 42.5	225 - 230			
130 - 135	0	0	0	77.5 - 80.0	210 - 215			
185 - 190	0	0	0	0 - 2.5	190 - 195			
Additional disclosure								
Band of the highest paid Director's total remuneration								
Median Total (£'000)		26,731						
Remuneration ratio		7						

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

Name and Title		2013 - 14					
	Salary	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonus	Pension Related Benefits	Total	
	(bands of £5,000) £000	(bands of £00) £00	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	
A Haigh ~ Chair	50 - 55	4 - 5	0	0	0	50 - 55	
A Fisher (Note A)	5 - 10	0	0	0	0	5 - 10	
D Anderson ~ Senior Independent Non Executive Director	10 - 15	0	0	0	0	10 - 15	
J Hanson (Note B)	5 - 10	4 - 5	0	0	0	5 - 10	
J Pease ~ Chair Quality Committee (Note C)	5 - 10	0	0	0	0	5 - 10	
J Wilson ~ Vice Chair & Chair of Health & Safety Committee	10 - 15	7 - 8	0	0	0	10 - 15	
L Patterson (Note D)	5 - 10	0	0	0	0	5 - 10	
P Oldfield ~ Chair Finance & Performance Committee (Note E)	5 - 10	0	0	0	0	5 - 10	
Prof P Roberts ~ Chair Audit & Risk Committee (Note F)	10 - 15	1 - 2	0	0	0	10 - 15	
W Jones (Note G)	0	3 - 4	0	0	0	0 - 5	
B Crosse ~ Medical Director (Note H)	175 - 180	0	0	0	277.5 - 280.0	455 - 460	
K Griffiths ~ Director of Finance	145 - 150	13 - 14	0	0	7.5 - 10.0	160 - 165	
L Hill ~ Director of Planning, Performance and Estates & Facilities	130 - 135	6 - 7	0	0	62.5 - 65.0	190 - 195	
J Hull ~ Director of Workforce and Organisational Development	125 - 130	0	0	0	42.5 - 45.0	170 - 175	
D Wise ~ Medical Director (Note I)	40 - 45	0	0	0	0	40 - 45	
H Thomson ~ Director of Nursing (Note K)	130 - 135	29 - 30	0	0	0	130 - 135	
O Williams ~ Chief Executive	185 - 190	19 - 20	0	0	22.5 - 25.0	215 - 220	
Additional disclosure							
Band of the highest paid Director's total remuneration	185 - 190						
Median Total (£'000)	26,907						
Remuneration ratio	7						

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

- A, A Fisher resigned 30.09.13
 B, J Hanson was Chair of Audit & Risk Committee and resigned 30.09.13
 C, J Pease appointed 01.10.13
 D, L Patterson appointed 01.10.13
 E, P Oldfield appointed 23.09.13
 F, Prof P Roberts was appointed Chair of Audit & Risk Committee 22.10.13
 G, W Jones resigned 11.11.12
 H, B Crosse appointed 17.06.13 and resigned 04.06.14
 I, D Wise resigned 15.06.13
 J, D Birkenhead - appointed as interim on 16.06.14 and appointed to the substantive position on 20.01.15
 K, H Thompson resigned 31.03.14
 L, J Dawes - appointed 01.04.14

The pension related benefits figure for 2013/14 has changed with us now excluding all negative figures.

B) Pension Benefits

Name and title	Real increase in pension at age 60 (bands of £2,500)	Real Increase in Lump sum at age 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2014	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2015
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
B Crosse ~ Medical Director	(10.0 - 12.5)	(5.0 - 7.5)	55 - 60	175 - 180	1,413	(191)	1,260
K Griffiths ~ Director of Finance	0 - 2.5	0 - 2.5	50 - 55	160 - 165	906	34	964
L Hill ~ Director of Planning, Performance and Estates & Facilities	0 - 2.5	2.5 - 5.0	45 - 50	135 - 140	755	41	817
J Hull ~ Director of Workforce and Organisational Development	0 - 2.5	0 - 2.5	45 - 50	145 - 150	885	36	945
D Birkenhead ~ Medical Director	2.5 - 5.0	10.0 - 12.5	65 - 70	200 - 205	1,082	96	1,207
J Dawes ~ Director of Nursing	2.5 - 5.0	12.5 - 15.0	50 - 55	155 - 160	880	112	1,015
O Williams ~ Chief Executive	0 - 2.5	0	60 - 65	0	632	33	683

Cash Equivalent Transfer Values

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

Real Increase/ (Decrease) in CETV

As of 22nd July 2010 all CETV factors are based on Consumer Price Index (CPI)

Additional disclosures

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

The mid-point of the banded remuneration of the highest-paid director in Calderdale and Huddersfield NHS Foundation Trust in the financial year 2014/15 was £187.5k (the same as in 2013/14). As in 2013/14, this was 7 times the median remuneration of the workforce, which was, £26,731 (in 2013/14 it was £26,907).

An overpayment with a value of £18,444 was made to B. Crosse during 2013/2014 and recovered in 2014/2015.

B. Crosse was supported as a participant in a Kings Fund Leadership Development Programme at a cost of £6,954 in 2014/2015.

J Dawes was paid relocation expenses of £6,142 in 2014/2015.

Owen Williams**Chief Executive****On behalf of the Board of Directors****28 May 2015**

Audit And Risk Committee Report

I am pleased to present the Audit and Risk Committee report for 2014/15. The Committee's role is to review critically the governance and assurance processes on which the board places reliance, and as a consequence we remain focussed on the audit and risk processes to ensure the long-term viability of the organisation. The Committee is charged with ensuring the adequacy and effective operation of the overall control systems of the organisation, with specific focus on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives.

The Audit and Risk Committee has approved terms of reference which are reviewed annually and are available on request. The Committee is made-up of three independent non-executive directors, who have all been selected as members of the committee on the basis of their skills and expertise. Two Membership Councillors are also invited to attend each meeting. The Committee met six times during 2014/15. The attendance at the Committee for the financial year 2014/15 was:

NAME	ATTENDANCE AT AUDIT COMMITTEE MEETINGS 01/04/2014 – 31/03/2015			
	29.5.15	22.7.14	27.10.14	20.1.15
Prof Peter Roberts (Chair)	✓	✓	✓	✓
Philip Oldfield	✓	✓	✓	✓
Jan Wilson	✓	✓	✓	✓

Although not members of the Committee, the Executive Director of Finance, Executive Director of Nursing and Operations, Deputy Director of Finance and Company Secretary attend each meeting. The Audit and Risk Committee is assisted in its work through the routine attendance at meetings of our internal auditors, our counter-fraud specialist and our external auditors. If necessary we are also able to seek independent legal or other professional advice.

The Committee is keen to interact with other executives and senior managers. Representatives from finance and the wider organisation have attended at the Committee's request.

The principal activities of the Committee over the year were:

Financial Reporting

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

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

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

The four key areas of judgement for the 2014/15 financial statements considered by the Committee were:

- the entities within the scope of the consolidation of the Trust's annual accounts;

The Director of Finance confirmed to the Committee that the Trust would prepare consolidated financial statements for the Trust and charitable funds. This was consistent with the prior year scope, remains an appropriate treatment of the Trust and charitable funds and is compliant with the relevant accounting standards and the Annual Reporting Manual as issued by Monitor.

The Director of Finance also confirmed that equity accounting was the relevant treatment for the Trust's interest within the Joint Venture partnership of Pennine Property Partnership LLP and is compliant with the relevant accounting standards and the Annual Reporting Manual as issued by Monitor.

- the provision of liabilities;

The Trust has made provision for future liabilities within the financial statements. As part of the year end reporting process, the external auditor has reviewed the appropriateness of these provisions and has confirmed to the Committee that they represent a 'cautious' position.

- the revaluation of fixed assets;

The Committee has reviewed the revaluation of fixed assets that have been recognised in accordance with the relevant accounting policy. As part of the year end reporting process, the external auditor has reviewed the District Valuer's fixed asset valuation report and confirms the Trust has applied this report in the correct way.

- the evidence to support the Trust's going concern status.

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

As described within the Annual Report, the Trust was required to reforecast the financial plans for 2014/15. The Committee considered this reforecast position and accompanying narrative as part of the submission process to the Trust's regulator, Monitor.

In addition, and on a quarterly basis, the Committee considered the financial statements that formed part of the quarterly reporting submission to Monitor.

Governance and Risk Management

During the course of the year the Committee has continued to ensure the Trust's governance arrangements are reviewed in-line with the Code of Governance for Foundation Trusts published by Monitor.

Any changes are reflected within the relevant Trust policies and procedures and reported to the Committee for approval. In the early part of 2014/15 the Committee approved updates to the following key documents:

- The Standing Orders
- The Standing Financial Instructions
- Scheme of Delegation

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

Of particular importance is the review of the disclosure statements that flow from the Trust's assurance processes with internal control weaknesses described within the Annual Governance Statement.

The Committee discussed and agreed upon the disclosed areas of internal control gaps as described within the 2014/15 Annual Governance Statement.

Following the 2013/14 Trust-wide review of governance and risk management processes, the Committee has continued to follow the progress of this programme of work with the Committee specifically focused on the improvement work being undertaken with the Board Assurance Framework and associated risk management processes that exist within the Trust.

Regulatory Relationships

The Committee is briefed by the Executive Directors on the Trust's relationship with its key regulators and any significant changes that affect the Trust's operational environment.

Within 2014/15 the following key items were discussed:

- reports from Monitor following the submission of the Trust's reforecast plan;
- the enforcement actions following Monitor's review into the Trust's financial position;
- the Trust's response with regards to new governance arrangements in response to turnaround and cost improvement planning;
- site and service inspection reports from the Care Quality Commission (CQC).

Internal Audit and Counter Fraud

The internal audit and counter fraud service is supplied by the West Yorkshire Audit Consortium (WYAC).

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

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

Within the year the following specific, additional work programmes were requested by the Committee:

- Cost Improvement Programme and Budgetary Control Review
- Risk Assessment and Governance Structure Review of the Outline Business Case relating to Transforming Health and Social Care within Calderdale and Greater Huddersfield.

The plans as agreed for 2014/15 and the additional work programmes were completed and culminated in an annual opinion from the Head of Internal Audit (HOIA).

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

External Audit

The external audit service is provided by KPMG LLP (KPMG). KPMG was appointed on 1 October 2012 following a market testing exercise in the summer of 2012.

The appointment process followed the guidance issued by Monitor and resulted in the approval of KPMG by the Membership Council at their meeting in September 2012.

A three year contract was awarded to KPMG with options to extend or terminate in accordance with the conditions of the contracts. The three year contract is in-line with Monitor's recommendations that NHS Foundation Trusts undertake a market testing exercise at least once every five years.

The Committee recognise that non-audit related services can be provided by KPMG. In order to maintain KPMG's independence, the Committee has been informed of the robust internal procedures that KPMG apply when considering the undertaking of any non-audit services. In addition to this control, any significant non-audit services would require the pre-approval of the Committee.

In the year 2014/15 there were no significant non-audit related services provided by KPMG.

The Committee reviewed and approved the External Audit plan for 2014/15. The auditors explained the programme of work they planned to undertake to ensure that the identified audit risks did not lead to a material misstatement of the financial statements and it is through the monitoring of this audit plan that the Committee gain assurance of the quality and effectiveness of the service received from KPMG.

The key audit risks they identified for 2014/15 were:

- Valuation of fixed assets;
- Revenue recognition;
- Accounting for joint ventures;
- Management over-ride of controls;

As part of the year end audit process the auditor confirmed that there are no material misstatements within the financial statements. The auditors also reported the misstatements that they had found in the course of their work and confirmed that there are no material items remaining unadjusted within the financial statements.

Expressions of Concern, including Whistleblowing

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



NHS Foundation Trust Code Of Governance and Other Disclosures

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

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

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

Comply or explain

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

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

As a licensee, the Trust is required to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. To do this, the Trust has regard to guidance from Monitor, the sector regulator for healthcare, including the NHS Foundation Trust Code of Governance.

All directors and governors have signed a declaration indicating their compliance with the "fit and proper persons" test introduced through condition G4 of the provider licence.

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

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

Mandatory disclosures

Code provision	Requirement	Location in Annual Report
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Strategic Report Page 11 Our Membership Council Page 50
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Directors' Report Board of Directors page 44
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Governance Our Membership Council Page 50
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Governance Our Membership Council Page 50
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Directors' Report Board of Directors page 44
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Director's Report Board of Directors page 44
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Directors' Report Board of Directors page 44
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Governance Remuneration Committee report page 122
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Governance Remuneration Committee report page 122
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	The Chair has no other significant commitments to disclose
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Strategic Report page 11 In 2014, the Trust published its Strategic Outline Case and then Outline Business Case for a major reconfiguration of services. As part of the engagement and consultation process, Membership Councillors provided engagement opportunities for the public to provide insight and feedback on the plans.

Code provision	Requirement	Location in Annual Report
FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.	This power has not been exercised in 2014/15
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Directors' Report Board of Directors page 44
B.6.2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	Directors' Report Board of Directors page 44
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Statement of the Accountable Officer Page 136 Statement of the Auditor Page 146 Annual Governance Statement Page 137
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement Page 137
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement Page 137
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable in this financial year
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: – the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; – an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Governance Audit and Risk Committee Report page 128
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable. No executive directors have been released to service as a non-executive elsewhere.
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Governance Our Membership Council Page 50
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Strategic Report Page 11 Governance Our Membership Council Page 50

Code provision	Requirement	Location in Annual Report
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Governance Our Membership Council Page 50
FT ARM	The annual report should include: <ul style="list-style-type: none"> • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members. 	Governance Our Membership Council page 50
FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	Governance Our Membership Council page 50

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

Comply or explain disclosures

The Trust complied with all relevant provisions of the code.

Other disclosures in the public interest

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

Summary of disclosure required	
Actions taken to maintain or develop the provision of information to, and consultation with, employees;	p37
The foundation trust's policies in relation to disabled employees and equal opportunities;	p23
Information on health and safety performance;	p23
Information on policies and procedures with respect to countering fraud and corruption;	p130
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998	px24
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year;	N/A
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Accounts
A statement that the NHS foundation trust has complied with the cost allocation and charging guidance issued by HM Treasury	Accounts
Details of serious incidents involving data loss or confidentiality breach	No incidents.

Voluntary disclosures

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

Summary of disclosure	
Sustainability reporting	Strategic Report p23
Equality reporting	Directors' Report p38
The NHS Constitution	Strategic Report p19

Statement of the Chief Executive's Responsibilities as the Accounting Officer of Calderdale and Huddersfield NHS Foundation Trust

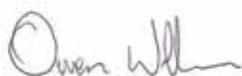
The NHS Act 2006 states the Chief Executive is the accounting officer of the Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Calderdale and Huddersfield NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Calderdale and Huddersfield NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year. In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

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

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



Owen Williams,
Chief Executive
Date: 28 May 2015

Annual Governance Statement 2014/15

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Calderdale and Huddersfield NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

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

- Audit and Risk Committee
- Quality Committee
- Finance and Performance Committee
- Health and Safety Committee

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit & Risk Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given to the Board of Directors by the Quality Committee. The Board of Directors routinely receives the minutes of these Committees alongside the Board Assurance Framework. The Risk and Compliance Group oversees all risk management activity to ensure: (a) the correct strategy is adopted for managing risk; (b) controls are present and effective; and (c) action plans are robust for those risks that remain intolerant. The Risk and Compliance Group is chaired by the Executive Director of Nursing and comprises senior management representation from all divisions. Other

senior managers and specialist advisors routinely attend each meeting. While the Risk and Compliance Group reports directly to the Audit and Risk Committee, it also provides a monthly report on the high level risks and mitigating actions to the Board and works with other committees of the Board in order to triangulate material issues in accordance with the Board's appetite for taking risk and ensure a coordinated approach to effective risk management.

The Trust has recently reviewed and updated the Risk Management Policy that clearly describes the process for managing risk and the roles and responsibilities of staff. The Policy sets out a clear, systematic approach to risk management that ensures it is an integral part of the clinical, managerial, quality and financial processes within the organisation. Risks are identified, managed and reviewed at a department, directorate and divisional level as appropriate.

The Trust has recently reviewed and refreshed its programmes of generic and specific risk management training. In addition the Board has set out the minimum requirements for staff training required to control key risks and has refreshed the mandatory training programme to ensure that it continues to meet the needs of all staff. This includes infection control, safeguarding adults and children, information governance and manual handling. We also have a health & safety training programme from Board to ward. The new mandatory training framework describes the requirements for each staff group and the frequency of training in each case. Risk management training is also a key part of induction for all new starters.

Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons learned and to help improve internal control and are reported to the Board through the quarterly Quality Report. The lessons learned are shared with staff across the Trust through a number of ways including the safety bulletin '*So what happened next?*' We also rigorously apply national guidance including the recommendations from investigations and enquiries.

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

The risk and control framework

Calderdale and Huddersfield NHS Foundation Trust take action to manage risk to a level which is tolerable. We acknowledge that risk can rarely be totally eradicated and will accept a level of managed residual risk. Risk management requires active participation and commitment from all staff. It is an intrinsic part of the way the business of the Trust is conducted and its effectiveness is monitored by the Trust's performance management and assurance systems. The risk management process is set out in six key steps as follows:

i. Determine priorities

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

ii. Risk Identification

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

iii. Risk Assessment

Risk assessment involves the analysis of individual risks, including analysis of potential risk aggregation where relevant. The assessment uses the standard 5x5 matrix detailed in the Risk Management Policy which evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

iv. Risk Response

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

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

v. Risk Reporting

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

vi. Risk Review

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

Incident reporting and investigation is recognised as a vital component of risk and safety management and is key to being a learning organisation. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and routine mandatory training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

Operational risk registers are maintained in every ward and department, and for time limited projects. Divisional registers consolidate directorate risks scoring 8 or above and any additional business risks to the division. Divisional registers are cross-referenced to the divisional business plan.

These assurance processes allow the Board to issue an accurate Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b) of Monitor's provider licence.

During the year the Board has driven a review of the Board Assurance Framework to ensure that it addresses the risks to the strategic objectives of the Trust. The revised Board Assurance Framework was signed off by the Board for 2014/15 at its meeting in March. The new BAF, developed alongside the revised annual plan, will be reviewed on a quarterly basis as a minimum.



An independent governance review process was undertaken in 2013/14 which highlighted a number of strengths of the Board, including its clear commitment to quality and patient safety. One of the areas highlighted for development was to streamline the governance arrangements and review the risk management arrangements across the Trust. These actions were incorporated into a wider governance development plan which has been implemented during 2014/15 including:

- A revised Quality Committee with a focus on providing assurance to the Board on the quality of its services and the quality and equality impact of any activities;
- Streamlining of the sub-group arrangements under the Quality Committee to align them with the Care Quality Commission domains of safe, caring, responsive, effective and well-led.
- Strengthening of the risk assurance responsibilities of the Audit and Risk Committee;
- The creation of a Finance and Performance Committee to ensure that financial risks are identified in light of any

performance issues and then are robustly managed and mitigated;

- Strengthening the responsibilities and membership of the Risk and Compliance Group;
- Development of the monthly risk register report to the Board of Directors;
- Further development of the Board Assurance Framework to clarify its relationship with the corporate risk register and to ensure its alignment to the strategic objectives.
- Embedding of the risk management arrangements with a detailed review of all risk registers and revised risk management training at all levels

The monthly risk report to the Board of Directors is available in the public papers of the meeting. Key risks affecting the Trust are discussed with the local Overview and Scrutiny Committees and HealthWatch to ensure that there is transparency on the risks, how they are being mitigated and managed and the way in which members of the public and stakeholders can contribute.

Significant risks facing the Trust

As at 31 March 2015 Calderdale and Huddersfield NHS Foundation Trust had identified a number of risks, which are being managed and mitigated, which could impact on the achievement of corporate objectives, compliance with the Monitor licence or CQC in the following areas:

- Breach of Monitor's Provider licence due to failure to deliver the financial plan and cost improvement programme
- Inability to progress service reconfiguration impacting on the quality and safety of services
- Exposure to Healthcare Associated Infections, in particular C Difficile
- Adequacy of nurse staffing levels and ability to recruit
- Supply of medical workforce in particular specialist areas
- Compliance with A&E 4-hour Target due to poor patient flow and low numbers of discharges
- Inability to reduce the Hospital Standardised Mortality Ratio and Summary Hospital-level Mortality Indicator
- Ability to implement the electronic patient record

These risks are clearly described in the corporate risk register which sets out the arrangements for risk treatment, risk appetite thresholds and the planned further mitigating actions. This is reviewed by the full Board at each formal meeting. There will also be a controls assurance review undertaken by the Audit and Risk Committee.

In addition the Board reviews the Integrated Board Report which sets out the operational, quality, financial and workforce performance targets and indicators. Each is assigned to an executive lead who is accountable for the achievement of the target and ensuring appropriate monitoring is in place.

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

- reporting and keeping under review matters highlighted within the Care Quality Commission's Intelligent Monitoring Report and inspections;
- liaising with the Care Quality Commission Compliance Inspectors and divisional senior clinicians and managers in response to any specific concerns that are raised with the Care Quality Commission by patients and members of the public;
- engaging with the Care Quality Commission Compliance Inspectors on the inspection process and co-ordinating the Trust's response to inspections and any recommendations or actions that arise;
- analysing trends from incident reporting, complaints, and patient and staff surveys and sharing the learning from these across the Trust;
- reviewing assurances on the effective operation of controls;
- receiving details of assurances provided by Internal Audit and any clinical audit conclusions which provide only limited assurance on the operation of controls; and
- challenging assurances or gaps in assurance through chairing the Risk and Compliance Group

Calderdale and Huddersfield NHS Foundation Trust is required to register with the Care Quality Commission and has full registration without conditions. The Care Quality Commission has not taken enforcement action against the Trust during 2014/15. The Trust has not participated in any special reviews or investigations by the Care Quality Commission during the year.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

Calderdale and Huddersfield NHS Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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

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

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

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

The Board agrees annually a set of strategic corporate objectives which are communicated to colleagues. This provides the basis for appraisals at all levels. The Board keeps operational performance and delivery against the objectives

under constant review through scrutiny at each meeting of the Integrated Board Report covering patient safety, quality, access and experience metrics in addition to a finance performance report. In addition, detailed review of the quality aspects of the Integrated Board Report is undertaken each month by the Quality Committee. Additional financial scrutiny is also provided by the Finance and Performance Committee each month.

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

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Trust has at its disposal. Assurances on the operation of controls are commissioned and reviewed by the Audit and Risk Committee and, where appropriate, the Quality Committee or other subcommittee of the Board of Directors as part of their annual cycle of business. The implementation of recommendations made by Internal Audit is overseen by the Audit and Risk Committee.

In the first quarter of the year, it became clear to the Board of Directors that the Trust was facing significant financial challenges and would not deliver the original financial plan.

A re-forecast plan was submitted in September 2014 to the regulator which resulted in an investigation by Monitor and the Trust was found to be in breach of its licence in January 2015. The Trust sought independent support to review its financial management and governance arrangements. This resulted in the development of the strengthened Finance and Performance Committee and the implementation of the Programme Management Office arrangements to oversee and support the development and implementation of robust cost improvement plans for 2015/16 and 2016/17. In addition, the Board accepted a number of enforcement undertakings including delivery of the reforecast plan by the year-end; development of robust plans for 2015/16; a Well-Led Governance Review to be undertaken in Q1 of 2015/16 and the development of a strategic turnaround plan by September 2015. The Trust also put in place turnaround arrangements with the appointment of an Interim Turnaround Director and the creation of a Turnaround Executive to challenge and ensure delivery of the plans. The Audit and Risk Committee requested an Internal Audit of the cost improvement programme arrangements which reported in January.

The turnaround challenge and governance processes are being replicated at a divisional level alongside strengthened performance reporting and scrutiny to ensure that there are clear lines of accountability for delivery throughout the organisation.



Information Governance

Information governance is extremely important to us. The Trust uses the Connecting for Health Information governance toolkit framework to assist in the identification of risks and weakness in relation to its information assets, including the systems and media used in processing and storing of information. The existing framework is used for the process of identification, analysis, treatment and evaluation of potential and actual information governance risks, with risks being recorded on the relevant Divisional or Corporate Risk Register. The Trust's Senior Information Risk Owner (SIRO) supported by information asset owners, is responsible for the information risk programme within the Trust, and works closely with the Caldicott Guardian.

There has been 1 Information Commissioner's Officer (ICO) reportable (at level 2) incident in the last 12 months. The incident was relating to information security when sending personal identifiable data via email. This incident was reported in March 2015 and is currently under consideration by the ICO.

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

Confidentiality and information security awareness training is provided to all staff in the Trust's Induction Programme and through mandatory annual Information Governance training which is monitored by the Board through the Integrated Board Report. Training is also targeted at specific areas or staff groups on a risk basis. Progress with Information Governance compliance is measured on a yearly basis through the Trust's self-assessment against the Connecting for Health Information Governance Toolkit.

Annual Quality Report

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

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

Executive Director of Nursing, Executive Medical Director, clinical Divisional Directors and Assistant Divisional Directors of Nursing attend the Committee. To support robust triangulation of finance and quality issues, the Executive Director of Finance also attends the Committee.

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

There is clear clinical leadership for the development of the Annual Quality Report each year by the Executive Director of Nursing, in close collaboration with the Executive Medical Director. Both the Quality Committee and the Membership Council receive assurance on the progress against the priorities and outcomes highlighted within the Annual Quality Report. The Quality Committee is responsible for overseeing the production of the Annual Quality Report and for overseeing monitoring indicators and data quality. The Trust has engaged with its membership to develop the shortlist of quality priorities for 2015/16 and then tested these further with partner organisations, including Calderdale HealthWatch, Kirklees HealthWatch, NHS Calderdale Clinical Commissioning Group and NHS Greater Huddersfield Clinical Commissioning Group.

A limited scope assurance report is provided by external audit on the content of the quality account and selected key performance indicators. The external audit of the quality account found issues with the 18 week indicator. The issues identified related to:

- Patient records not being available
- Data not agreeing to patient notes
- Evidence of duplicate episodes

The external auditors have made one recommendation which the Trust intends to take action to address.

The Quality Committee revised its sub-group arrangements during 2014/15 to reflect the Care Quality Commission domains and to take forward and evaluate safety, patient experience, clinical effectiveness and outcomes, and well-led arrangements. The Quality Committee also seeks to learn from recommendations from national reports and inquiries including Saville and Kirkup. The Trust will continue to strive towards the provision of excellent service in response to these reports.

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

During 2014/15, there has been further development of the quality and safety metrics in the Integrated Board Report with information in relation to incidents and complaints trends; serious incidents; duty of candour compliance and patient experience data.

The Committee has reviewed the data in relation to its quality and accuracy. A data quality indicator has been included in the Integrated Board Report and this will be further



developed during 2015/16. The Quality Committee sought assurance on the information relating to 18 week referral to treatment times on both open and closed pathways and in particular those patients waiting between 18 and 26 weeks. The Trust has procured an electronic patient record which will be implemented during 2015/16 and 2016/17. Data quality management has therefore focused on continuing to address data quality issues identified through audit or through operational experience and addressing any new data quality standards mandated nationally or through commissioning requirements

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account attached to this report and other performance information available to me. My review

is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Board committees and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Board of Directors

The Board has set out the governance arrangements including the committee structure within the Standing Orders and its Constitution. The Chairs of the Board's Committees report to the Board at the first available Board meeting after each committee meeting. Urgent matters are escalated by the committee chair to the Board as appropriate. The Board has agreed, in conjunction with the Membership Council, the strategic objectives for the Trust. The Executive Directors have assessed the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in the Trust's Board Assurance Framework document reviewed regularly by the Board of Directors.

Audit and Risk Committee

The Audit and Risk Committee is responsible for establishing an effective system of internal control and risk management and provide an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity supported by the internal auditors who provide opinions on compliance with standards and the systems of internal control. The Committee ensures that any recommendations from these audits are implemented. The Committee also reviews, on a regular basis, the risks that are described within the Trust's Board Assurance Framework. The Committee has oversight of, and relies on the work of the Risk and Compliance Group to monitor the risk management process and risk registers.

Quality Committee

The Quality Committee monitors a range of quality metrics, and ensures that the Foundation Trust has robust systems in place to learn from experience. It receives reports from specialist governance committees e.g. Safeguarding; Information Governance; Medicines Management and assures itself that Divisional Quality Boards are receiving assurance on the quality of their services. The Quality Committee is chaired by a Non-Executive Director and reports to the Board of Directors.

These documents and internal and external audits of specific areas of internal control provide the Board of Directors with the information it requires to gain assurance that the Trust is meeting its objectives to protect patients, staff the public and other stakeholders against risks of any kind: which allows the Board to support me in signing this Annual Governance Statement.

Internal Audit

The Internal Audit reports issued in the year have given significant assurance that there is a generally sound system of internal control. However, some weakness in the design and/or inconsistent application of controls put the achievement of certain objectives at risk. There were ten internal audits which received limited assurance. In particular an audit of payroll showed that documentation selected for audit testing could not always be located. Due to this assurance could not always be provided on the completion and proper approval of forms which result in changes to payroll. As a result further audit work was undertaken by KPMG as part of the annual accounts audit. Action plans were agreed with management in all these areas and progress is reported in detail to each subsequent Audit and Risk Committee meeting as part of Internal Audit's follow up process. These reviews have shown significant progress has been made in implementing the action plans in many of the individual audit report areas. There have been no 'No Assurance' reports this year. Full detail of the limited assurance reports is available in the Head of Internal Audit Opinion, which is available on the Trust website at www.cht.nhs.uk

External Audit

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

Significant matters in-year

In addition to the breach of the Trust's licence with Monitor (p141) and the level 2 information governance incident (p142) the Trust had a number of other significant matters during 2014/15:

- The Trust did not meet the national requirement for 95% of patients to be seen in A& E within 4 hours, achieving 94.55%. Achievement of the target was impacted upon by the increased length of stay and difficulty in discharging patients at both sites. The Trust has put in place improvements in the discharge pathway and will continue to work with partners to improve patient flow through the hospitals.
- While the Trust has made significant improvements in infection prevention over recent years, we did not achieve the challenging target for rates of the incidence of clostridium difficile infections. The Trust has in place a detailed infection prevention action plan including specific interventions to minimise risk for patients and improve the control of infection throughout the Trust. This will continue to be a focus for the Trust during 2015/16.
- The Trust received a Regulation 28 Prevention of Future Death Report from HM Coroner. A detailed action plan was submitted to the Coroner and is being implemented.
- Significant gaps in nurse staffing levels were identified early in 2014/15 and the Trust Board made a decision to agree an investment of £1.5M to address these shortfalls and enable recruitment.
- The Trust's HSMR / SHMI remains above the national average. The Trust is continuing to implement the Care of the Acutely Ill Patient programme. Progress against each of the 8 themes with clear targets and areas of work is overseen by the clinical outcomes group on a monthly basis reporting through the Trust's Quality Committee to Board of Directors.
- There were 107 reported serious incidents during the year. Each case has been investigated and reported to local commissioners. Detailed action plans are developed in response to specific cases.

Conclusion

The system of internal control has been in place in Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

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

Owen Williams
Chief Executive
28 May 2015



INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Opinions and conclusions arising from our audit

1 *Our opinion on the financial statements is unmodified*

We have audited the financial statements of Calderdale and Huddersfield NHS Foundation Trust for the year ended 31 March 2015. These financial statements comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and related notes. In our opinion:

- the financial statements give a true and fair view of the state of the Group's affairs as at 31 March 2015 and of the Group's income and expenditure for the year then ended; and
- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 *Our assessment of risks of material misstatement*

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows:

Valuation of land and buildings - £191.85 million

Refer to the Audit Committee Report within the 'Directors Report' on the Trust's Annual Report and Accounts, Section 1.6 of Note 1 to the Accounts (accounting policies) and Property, plant and equipment financial disclosures at Note 14 to the Accounts.

The risk: Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialization, as well as over the assumptions made in arriving at the valuation. In particular the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation. Further, replacement cost is decreased if VAT on replacement costs is recoverable due to the transfer of assets to a property management subsidiary and so an assumption is required as to whether recovery will be made.

For 2014/15 an interim "desk-top" revaluation of all of the land and buildings, which did not involve the physical inspection of the assets, was undertaken by an external valuer. There is thus a risk that the valuation may not reflect the current use or condition of the assets.

Our response: In this area our audit procedures included:

- assessing the competence, capability, objectivity and independence of the Trust's external valuer and considering the terms of engagement of, and the instructions

issued to, the valuer for consistency with the requirements of the NHS Foundation Trust Annual Reporting Manual

- reviewing the basis of valuation of material assets and considering its appropriateness
- undertaking appropriate work to understand the basis upon which any impairments to land and buildings were classified, reviewing the associated assumptions and the Trust's accounting treatment; and
- considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

Joint Venture – Asset Value £11.84 million

Refer to the Audit Committee Report within the 'Directors Report' on the Trust's Annual Report and Accounts, Section 1.2 of Note 1 to the Accounts (accounting policy) and Note 25 of the Accounts (financial disclosures).

The risk: The Trust entered into a joint venture with Henry Boot Development Ltd in 2011, setting up a 50/50 owned partnership called Pennine Property Partnership Ltd.

One of the buildings being redeveloped within the partnership became operational in 2014/15. This required the partnership to formally value the operational asset. The Trust equity accounted for its share of the assets and liabilities of the partnership in accordance with the provisions of the FT ARM .

Our response: In this area our audit procedures included:

- Reviewing the Trust's accounting treatment of the joint venture and testing of individual balances to supporting evidence.
- Reviewing the adequacy and completeness of the disclosures within the financial statements.

NHS Income Recognition – CCGs and NHS England £315.5 million

Refer to the Audit Committee Report within the 'Directors Report' on the Trust's Annual Report and Accounts, Section 1.3 of Note 1 to the Accounts (accounting policy) and Note 3 of the Accounts (financial disclosures).

The risk: The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up 98% of income from activities. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource accounts. The AoB exercise identifies mismatches between receivable and payable and income and expenditure balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements. For these financial statements the Trust identifies the specific cause, and accounts for the expected future resolution, of each individual difference. Mis-matches can occur for a number of reasons, but the most significant arise where:

- the Trust and commissioners record different accruals for completed periods of healthcare which have not yet been invoiced;

- accruals for out-of-area treatments not covered by direct contracts with commissioners, but authorised by, for example, GPs on behalf of commissioners, are not recognised by commissioners; or
- there is a lack of agreement over proposed contract penalties for sub-standard performance.

Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit

Our response: In this area our audit procedures included:

- comparing the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checking the validity of any significant variations between the actual income and the contract.
- inspecting confirmations of balances provided by the Department of Health as part of the AoB exercise and comparing the relevant receivables recorded in the Trust's financial statements to the payable balances recorded within the accounts of commissioners.

3 *Our application of materiality and an overview of the scope of our audit*

The materiality for the Group's financial statements was set at £7m. This has been determined with reference to a benchmark of income from operations (of which it represents slightly less than 2%). We consider income from operations to be more stable than a surplus related benchmark.

We report to the audit and risk committee any corrected and uncorrected identified misstatements exceeding £350,000, in addition to other identified misstatements that warrant reporting on qualitative grounds.

The Group has two reporting components and both of them are subject to audits for group reporting purposes performed by the Group audit team at one location in Acre Mill, Huddersfield. These audits cover 100% of group income, surplus for the year and total assets. The audits performed for group reporting purposes are all performed to materiality levels set individually for each component and ranged from £0.055m to £7m.

4 *Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified*

In our opinion:

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 *We have nothing to report in respect of the following matters on which we are required to report by exception*

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the annual report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group's performance, business model and strategy; or
- the section describing the work of the audit and risk committee does not appropriately address matters communicated by us to the audit and risk committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in respect of the above responsibilities.

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

Under Section 62(1) of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts, we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

The Trust incurred a normalised deficit in line with its revised forecast during the year ended 31 March 2015, compared with its initial forecast of a £3m surplus. Its Continuity of Service Risk Rating has reduced from 3 to 2. The Trust is planning to incur a £20 million deficit in 2015/16. This plan requires the Trust to achieve £14 million cost savings and relies on £14.9 million of financial support from the Department of Health which has not yet been confirmed.

As a result of these matters and those highlighted in the enforcement undertakings issued by Monitor on 29 January 2015, we are not satisfied that Calderdale and Huddersfield NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2015.

Certificate of audit completion

We certify that we have completed the audit of the accounts of Calderdale and Huddersfield NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Our certificate is qualified in accordance with paragraph 5.12 of the Audit Code as:

- We have not been able to satisfy ourselves that the trust has made proper arrangements for securing economy, efficiency and effectiveness.
- Whilst we have issued a limited assurance opinion in relation to the content of the quality report and one of the mandated indicators, emergency readmissions within 28 days of discharge from hospital, we have not issued an opinion in relation to the Trust's other mandated indicator, percentage of incomplete pathways within 18 weeks for patients on incomplete pathways.

Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The purpose of our audit work and to whom we owe our responsibilities

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



Trevor Rees

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants

1 St Peter's Square

Manchester

M2 3AE

29 May 2015

Annual Accounts 2014/15

For the 12 month period ended 31st March 2015



Calderdale & Huddersfield NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2015, have been prepared by the Calderdale & Huddersfield NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006

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

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

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

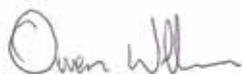
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

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

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

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

Signed



Owen Williams,
Chief Executive
Date: 28 May 2015

STATEMENT OF COMPREHENSIVE INCOME					
		Foundation Trust		Group	
		2014/15	2013/14	2014/15	2013/14
		£000	£000	£000	£000
Operating Income from continuing operations	3	354,467	353,274	354,721	353,634
Operating Expenses of continuing operations	4	(347,755)	(338,742)	(348,633)	(339,235)
OPERATING SURPLUS / (DEFICIT)		6,712	14,532	6,088	14,399
FINANCE COSTS					
Finance income	9	91	96	98	138
Finance expense - financial liabilities	10	(10,999)	(10,787)	(10,999)	(10,787)
Finance expense - unwinding of discount on provisions		(69)	(76)	(69)	(76)
PDC Dividends payable		(3,351)	(3,123)	(3,351)	(3,123)
NET FINANCE COSTS		(14,328)	(13,890)	(14,321)	(13,848)
Share of Profit / (Loss) of Associates/Joint Ventures accounted for using the equity method		211	-	211	-
Movement in fair value of investment property and other investments		1,142	-	1,142	12
Corporation tax expense			-		
Surplus/(Deficit) from continuing operations		(6,263)	642	(6,880)	563
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations		-	-	-	-
SURPLUS/(DEFICIT) FOR THE YEAR		(6,263)	642	(6,880)	563
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments *		(7,980)	(23,839)	(7,980)	(23,839)
Revaluations *		9,835	30,818	9,835	30,918
Other reserve movements		-	-	296	102
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		(4,408)	7,621	(4,729)	7,744
Prior period adjustment		-	-	-	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		(4,408)	7,621	(4,729)	7,744
Note: Allocation of Profits/(Losses) for the period:					
		2014/15	2013/14	2014/15	2013/14
		£000	£000	£000	£000
(a) Surplus/(Deficit) for the period attributable to:					
(i) minority interest, and		-	-	-	-
(ii) owners of the parent.		(6,263)	642	(6,880)	563
TOTAL		(6,263)	642	(6,880)	563
(b) total comprehensive income/ (expense) for the period attributable to:					
(i) minority interest, and		-	-	-	-
(ii) owners of the parent.		(4,408)	7,621	(4,729)	7,744
TOTAL		(4,408)	7,621	(4,729)	7,744

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

* The figures for 13/14 have been restated for revaluations and impairments to take into account the rolling up of the accumulated depreciation on land Building, and Dwellings into Gross Cost. There is no effect on the Net Book Value of the assets.

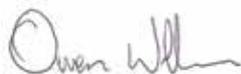
Group and Foundation Trust operating income for 2014/15 and 2013/14 includes an exceptional item relating to the reversal of impairments on property, plant & equipment of £316,000 and £935,000 respectively. Operating expenses for 2014/15 and 2013/14 include exceptional items relating to impairments on property, plant & equipment of £2,000,000 and £2,983,000 respectively.

The Group's surplus/(deficit) positions for 2014/15 and 2013/14, excluding these non-cash exceptional items, are (£5,196,000) and £2,611,000 respectively.

STATEMENT OF FINANCIAL POSITION					
		Foundation Trust		Group	
		31 March 2015	31 March 2014	31 March 2015	31 March 2014
	note	£000	£000	£000	£000
Non-current assets					
Intangible assets	12	1,241	997	1,241	997
Property, plant and equipment	13	221,734	209,159	221,734	209,159
Investments in associates (and joined controlled operations)		1,353	-	1,353	-
Other investments		-	-	2,341	2,614
Trade and other receivables	17	2,802	2,080	2,802	2,080
Total non-current assets		227,130	212,236	229,471	214,850
Current assets					
Inventories	16	5,973	5,687	5,973	5,687
Trade and other receivables	17	13,816	14,977	13,828	14,949
Other financial assets		-	-	73	100
Cash and cash equivalents	18	13,697	22,840	13,697	22,840
Total current assets		33,486	43,504	33,571	43,576
Current liabilities					
Trade and other payables	19	(35,923)	(34,977)	(36,003)	(34,996)
Borrowings	20	(1,997)	(1,449)	(1,997)	(1,449)
Other financial liabilities		-	-	-	-
Provisions	23	(3,392)	(3,126)	(3,392)	(3,126)
Other liabilities	22	(1,166)	(1,150)	(1,166)	(1,150)
Total current liabilities		(42,478)	(40,702)	(42,558)	(40,721)
Total assets less current liabilities		218,138	215,038	220,484	217,705
Non-current liabilities					
Trade and other payables	19	(329)	(281)	(329)	(281)
Borrowings	20	(87,445)	(81,440)	(87,445)	(81,440)
Other financial liabilities		-	-	-	-
Provisions	23	(2,404)	(2,806)	(2,404)	(2,806)
Other liabilities	22	(1,450)	(1,546)	(1,450)	(1,546)
Total non-current liabilities		(91,628)	(86,073)	(91,628)	(86,073)
Total assets employed		126,510	128,965	128,856	131,632
Financed by (taxpayers' equity)					
Financed by (taxpayers' equity)					
Public Dividend Capital		115,687	113,734	115,687	113,734
Revaluation reserve		36,627	35,308	36,627	35,308
Income and expenditure reserve		(25,804)	(20,077)	(25,804)	(20,077)
Charitable fund reserves			-	2,346	2,667
Total taxpayers' equity		126,510	128,965	128,856	131,632

The financial statements on pages 194 to 228 were approved by the board on 28/05/15 and signed on it's behalf by:

Signed :



Owen Williams, Chief Executive Date : 28 May 2015

STATEMENT OF CHANGES IN EQUITY	Others' Equity		Taxpayers' Equity		
	Total	NHS Charitable Funds Reserves	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2014	131,632	2,667	113,734	35,308	(20,077)
Surplus/(deficit) for the year	(6,880)	(617)	-	-	(6,263)
Impairments	(7,980)	-	-	(7,980)	-
Revaluations - property, plant and equipment	9,835	-	-	9,835	-
Public Dividend Capital received	1,953	-	1,953	-	-
Other reserve movements	-	-	-	(536)	536
Other reserve movements - charitable funds consolidation adjustment	296	296	-	-	-
Taxpayers' and Others' Equity at 31 March 2015	128,856	2,346	115,687	36,627	(25,804)
	Total	NHS Charitable Funds Reserves	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2013	122,053	2,644	111,899	29,605	(22,095)
Surplus/(deficit) for the year	563	(79)	-	-	642
Impairments	(23,839)	-	-	(23,839)	-
Revaluations - property, plant and equipment	30,918	-	-	30,918	-
Public Dividend Capital received	1,835	-	1,835	-	-
Other reserve movements	102	102	-	(1,376)	1,376
Other reserve movements - charitable funds consolidation adjustment	-	(0)	-	-	0
Taxpayers' and Others' Equity at 31 March 2014	131,632	2,667	113,734	35,308	(20,077)

In year the Trust received £1,835,000 in relation to Department of Health funding for ward based IT investment.

STATEMENT OF CASH FLOWS					
	Foundation Trust			Group	
	2014/15		2013/14	2014/15	2013/14
	£000		£000	£000	£000
Cash flows from operating activities					
Operating surplus/(deficit) from continuing operations	6,712		14,532	6,088	14,399
Operating surplus/(deficit) from discontinued operations	-		-	-	-
Operating surplus/(deficit)	6,712		14,532	6,088	14,399
Non-cash income and expense:					
Depreciation and amortisation	9,365		10,592	9,365	10,592
Impairments	2,000		2,983	2,000	2,983
Reversals of impairments	(316)		(935)	(316)	(935)
(Gain)/Loss on disposal	(12)		58	(12)	58
Non-cash donations/grants credited to income	-		(101)	-	-
(Increase)/Decrease in Trade and Other Receivables	1,109		(3,530)	1,109	(3,527)
(Increase)/Decrease in Inventories	(286)		(470)	(286)	(470)
Increase/(Decrease) in Trade and Other Payables	462		1,746	462	1,744
Increase/(Decrease) in Other Liabilities	(80)		318	(80)	318
Increase/(Decrease) in Provisions	(205)		(3,269)	(205)	(3,269)
Tax (paid) / received	(100)		(9)	(100)	(9)
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	-		-	624	133
Other movements in operating cash flows	(15)		(24)	(15)	(25)
NET CASH GENERATED FROM/(USED IN) OPERATIONS	18,634		21,891	18,634	21,992
Cash flows from investing activities					
Interest received	91		96	91	96
Purchase of intangible assets	(502)		(720)	(502)	(720)
Purchase of Property, Plant and Equipment	(21,761)		(16,102)	(21,761)	(16,203)
Sales of Property, Plant and Equipment	134		2,198	134	2,198
Net cash generated from/(used in) investing activities	(22,038)		(14,528)	(22,038)	(14,629)
Cash flows from financing activities					
Public dividend capital received	1,953		1,835	1,953	1,835
Loans received from the Foundation Trust Financing Facility	7,000		-	7,000	-
Loans received from the Department of Health	1,000	*	1,050	1,000	1,050
Loans repaid to the Foundation Trust Financing Facility	-		(5,631)	-	(5,631)
Capital element of finance lease rental payments	(1,449)		(1,345)	(1,449)	(1,345)
Interest paid	-		(158)	-	(158)
Interest element of Private Finance Initiative obligations	(10,929)		(10,745)	(10,929)	(10,745)
PDC Dividend paid	(3,314)		(2,937)	(3,314)	(2,937)
Net cash generated from/(used in) financing activities	(5,739)		(17,931)	(5,739)	(17,931)
Increase/(decrease) in cash and cash equivalents	(9,143)		(10,568)	(9,143)	(10,568)
Cash and Cash equivalents at 1 April	22,840		33,408	22,840	33,408
Cash and Cash equivalents at 31 March	13,697		22,840	13,697	22,840

NOTES TO THE ACCOUNTS

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Foundation Trust Annual Reporting Manual 2014/15 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts.

The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Going Concern

The Trust has closed the year with a cash balance of £14m and positive net assets of £127m.

However, given the shape of the financial plans for 2015/16 there is a requirement for the Board of Directors to consider the impact these plans have on the organisation and hence must be able to demonstrate that the Trust is a going concern.

The following has been taken into account when the Board of Directors considered going concern:

- The Trust closed the year with £14m of cash but cannot sustain the planned deficit position within 2015/16 without the requirements of external cash support. As such, the Trust has been in communication with Monitor and the ITFF to arrange for working capital facilities to enable the Trust to operate throughout 2015/16 and is planning for a working capital loan of £14m. With this loan in place, the Trust will be able to meet its liabilities.
- The Commissioners continue to commission services from the Trust and although the Trust and Commissioners are yet to sign their main contracts for clinical services the Commissioners have continued with monthly transfers of fixed levels of cash based on contracted values for 2014/15. This incoming cash has enabled the Trust to meet all its obligations and liabilities within the first few months of 2015/16 and expect this funding to continue until contracts are signed with the associated revised cash flows.
- The PMO methodology has ensured that the CIP plans for 2015/16 are robust and deliverable. This programme methodology is built around a gateway approach for project design, development and delivery that includes a rigorous quality and equality impact assessment review.

The schemes within the planned CIP of £14m have all progressed through gateway 2 and these represent detailed plans that are ready for implementation with key milestones being tracked and monitored on a weekly basis through an Executive Director led Turnaround Executive meeting. In addition, the Trust has developed a further £3m of schemes that have progressed through gateway 2 at the end of April 2015 and the Trust is confident that within the total gateway 2 values of £17m, a minimum of £14m CIP will be delivered in line with the planned levels.

In conclusion the Board of Directors has a reasonable expectation that Calderdale and Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.

1.1 Accounting Convention

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

1.2 Consolidation

Subsidiaries

Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

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

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material. Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Calderdale & Huddersfield NHS foundation Trust is the corporate trustee to Calderdale & Huddersfield NHS Foundation Trust charitable fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

The charitable fund's statutory accounts are prepared to 31 March on accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the accounting policies of Calderdale and Huddersfield NHS Foundation Trust; and
- eliminate intra-group transactions, balances, gains and losses.

Joint Ventures

Joint ventures are separate entities over which the trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries. Joint ventures are accounted for using the equity method. Joint ventures which are classified as held for sale are measured at the lower of

their carrying amount and 'fair value less costs to sell'.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies

The management has had to make no critical judgements, apart from those involving estimations (see below) in the process of applying the Trust's accounting policies.

1.3.2 Key sources of estimation uncertainty

Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are included in the relevant accounting policy note.

The valuation of the Trust's land and buildings is subject to significant estimation uncertainty, since it derives from estimates provided by the Trust's external valuers who base their estimates on local market data as well as other calculations to reflect the age and condition of the Trust's estate.

1.3.3 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Given the low value of annual leave carried forward by employees across periods, and as this value does not change significantly between financial years, the cost of annual leave earned but not taken by employees at the end of the period is not recognised in the financial statements.

Pension costs

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

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

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

1.5 Expenditure on other goods and services

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

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

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

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

- individually has a cost of at least £5,000; or
- forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial

control; or

- forms part of the initial setting-up of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

Measurement

Valuation

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

All assets are measured subsequently at fair value.

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

A full revaluation was undertaken of all property assets as at 31 March 2014.

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

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

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

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

Investment property is initially measured at cost and subsequently at fair value with any change there in recognised in the statement of comprehensive income as revenue gains or losses

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

Until 31 March 2009, plant and equipment were carried at net current replacement cost, as assessed by indexation and depreciation. From 1 April 2009 the national equipment indices issued by the Department of Health are no longer available. The carrying value of existing assets at that date is being written off over their remaining useful lives and any new plant and equipment are carried at depreciated historical cost as these are considered to be a reasonable proxy for fair value.

Subsequent expenditure

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

Depreciation

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

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

Revaluation gains and losses

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

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

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

Impairments

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

An impairment that arises from a clear consumption of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve when the impairment reversal is recognised.

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

Derecognition

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

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

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

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

Donated assets

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

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

Private Finance Initiative (PFI) transactions

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

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

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

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

Protected assets

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

1.7 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

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

- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and

- the Trust can measure reliably the expenses attributable to the asset during development.

Software

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

Measurement

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

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

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

Amortisation

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

1.8 Government grants

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

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The Cost of inventories is measured using the First In, First Out (FIFO) method. The cost valuation is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Financial instruments and financial liabilities

Recognition

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

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

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

De-recognition

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

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

Classification and Measurement

Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other Financial liabilities'.

Loans and receivables

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

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

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

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

Other financial liabilities

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

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

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

Impairment of financial assets

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

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

1.11 Leases

Finance leases

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

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

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

Operating leases

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

Leases of land and buildings

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

1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at Note 23.3.

Non-clinical risk pooling

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

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23.4 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23.4, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

1.14 Public dividend capital

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

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) liabilities in relation to donated assets

(iii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF, excluding cash balances held in GBS accounts that relate to a short-term working capital facility and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax

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

1.16 Corporation Tax

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

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

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

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

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

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Third party assets

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

1.19 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.20 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

1.21 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2014-15. The application of the Standards as revised would not have a material impact on the accounts for 2014-15, were they applied in that year:

IFRS 9 Financial Instruments
 IFRS 13 Fair Value Measurement
 IFRS 15 Revenue from Contracts with Customers
 IAS 19 (amendment) - employer contributions to defined benefit Pension Scheme
 IAS 36 (amendment) - recoverable amount disclosures
 Annual Improvements 2012
 Annual Improvements 2013
 IFRIC 21 Levies

Note 2 Segmental Analysis

The Trust's core activities fall under the remit of the Chief Operating Decision Maker ("CODM") as defined by IFRS 8 'Operating Segments', which has been determined to be the Management Board, a sub-committee of the Board of Directors. These core activities are primarily the provision of specialist NHS healthcare, the income for which is received through contracts with commissioners. The planned level of activity is agreed with our main commissioners for the year, and are listed in the related party disclosure (see Note 22)

Healthcare

The large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore a segment of 'Healthcare' is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a distinct operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers this segment of healthcare in its decision-making process.

Charitable Funds

The charitable funds activity of the Foundation Trust are managed through The Calderdale and Huddersfield NHS Foundation Trust Charitable Funds. The day-to-day management of the charity is overseen by the Charitable Funds Committee which then reports to the Foundation Trust Board of Directors in its role as the Corporate Trustee. The financial position of the charity is reported separately to the Corporate Trustee throughout the year and is subject to separate decision making processes.

The two identified segments of 'the provision of healthcare' and 'charitable funding activities' are consistent with the core principle of IFRS8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

Note 2.1 Segmental Analysis	Healthcare		Charitable Fund		Total	
	2014/15	2013/14	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000	£000	£000
Income	354,467	353,274	254	360	354,721	353,634
Surplus / (Deficit)	(6,263)	642	(617)	(79)	(6,880)	563
Net Assets	126,510	128,965	2,346	2,667	128,856	131,632
Note 3 Operating Income						
Note 3.1 Operating Income by classification						
	2014/15		2013/14			
	£000		£000			
Income from activities						
Elective income	55,076		52,383			
Non elective income	83,445		85,031			
Outpatient income	39,338		38,978			
A & E income	14,059		14,024			
Other NHS clinical income	123,981		124,954			
Private patient income	517		504			
Other non-protected clinical income	4,093		5,144			
Total income from activities	320,509		321,018			
Other operating income						
Research and development	1,186		987			
Education and training	8,879		8,280			
Received from NHS charities: Cash donations / grants for the purchase of capital assets	470		101			
Received from NHS charities: Other charitable and other contributions to expenditure	338		380			
Non-patient care services to other bodies	10,651		10,712			
Other *	12,023		10,794			
Reversal of impairments of property, plant and equipment	316		935			
Rental revenue from operating leases - Minimum lease receipts	89		62			
Rental revenue from operating leases - contingent rent	6		4			
NHS charitable funds: Incoming resources excluding investment income	254		361			
Total other operating income	34,212		32,616			
Total operating income	354,721		353,634			
Note 3.2 Commissioner and non-commissioner requested services						
	2014/15		2013/14			
	£000		£000			
Commissioner and non-commissioner requested Goods and Services	354,721		353,634			

* other operating Income of £12m includes £6.8m sales of manufactured pharmaceutical products, £1.4m car parking income, £0.3m property rental income, £0.6m catering income (In 2013/14 the comparative figures were £5.4m for sale of manufactured in pharmaceutical products, £0.7m car parking income, £0.3m property rental income, £0.9m catering income).

Note 3.3 Operating lease income				
	2014/15	2013/14		
	£000	£000		
Operating Lease Income				
Rental revenue from operating leases - Minimum lease receipts	89	62		
Rental revenue from operating leases - contingent rent	6	4		
TOTAL	95	66		
Future minimum lease payments due				
- not later than one year;	32	32		
- later than one year and not later than five years;	16	16		
- later than five years.	21	24		
TOTAL	69	72		
Future minimum lease income due all relate to building leases.				
Note 3.4 Operating Income by type				
	Foundation Trust		Group	
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Income from activities				
NHS Foundation Trusts	67	-	67	-
NHS Trusts	330	207	330	207
CCGs and NHS England	315,503	315,143	315,503	315,143
Local Authorities	(47)	128	(47)	128
Department of Health - other	0	20	0	20
Non NHS: Private patients	517	504	517	504
Non-NHS: Overseas patients (chargeable to patient)	164	64	164	64
NHS injury scheme (was RTA)	1,890	2,062	1,890	2,062
Non NHS: Other *	2,085	2,890	2,085	2,890
Total income from activities	320,509	321,018	320,509	321,018
Other Operating Income (See note 3.1 for break down)	33,958	32,256	34,212	32,616
TOTAL OPERATING INCOME	354,467	353,274	354,721	353,634

The negative income within Local Authorities relates to a credit note for discontinued services.

Note 4 Operating Expenses				
	Foundation Trust		Group	
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Services from NHS Foundation Trusts	6	20	6	20
Services from NHS Trusts	1,871	1,908	1,871	1,908
Services from CCGs and NHS England	22	38	22	38
Purchase of healthcare from non NHS bodies	1,358	1,631	1,358	1,631
Employee Expenses - Executive directors	937	894	937	894
Employee Expenses - Non-executive directors	155	147	155	147
Employee Expenses - Staff	220,543	217,020	220,543	217,020
Supplies and services - clinical (excluding drug costs)	28,652	29,054	28,652	29,054
Supplies and services - general	2,788	2,781	2,788	2,781
Establishment	4,638	4,741	4,638	4,740
Research and Development - (Not Included in employee expenses)	5	9	5	9
Transport (Business travel only)	22	134	22	134
Transport (other)	250	290	250	290
Premises	25,601	26,664	25,601	26,664
Increase / (decrease) in bad debt provision	(329)	822	(329)	822
Increase in other provisions	1,971	(1,060)	1,971	(1,061)
Change in provisions discount rate(s)	-	27	-	27
Drugs Inventories consumed	28,752	25,755	28,752	25,755
Rentals under operating leases - minimum lease receipts	4,672	4,327	4,672	4,327
Rentals under operating leases - sublease payments	(6)	(6)	(6)	(6)
Depreciation on property, plant and equipment	9,107	10,457	9,107	10,457
Amortisation on intangible assets	258	135	258	135
Impairments of property, plant and equipment	2,000	2,983	2,000	2,983
audit services- statutory audit	58	101	58	89
audit services -regulatory reporting	12	10	12	12
Audit fees payable to external auditor of charitable fund accounts			4	4
Clinical negligence	7,295	6,915	7,295	6,915
Loss on disposal of other property, plant and equipment	(12)	58	(12)	58
Legal fees	222		222	-
Consultancy costs	2,016	1,387	2,016	1,387
Training, courses and conferences	939	865	939	865
Redundancy - (Not included in employee expenses)	3,301	-	3,301	-
Hospitality	2	-	2	-
Insurance	1	-	1	-
Redundancy - (Included in employee expenses)	-	526	-	526
Losses, ex gratia & special payments- (Not included in employee expenses)	-	84	-	84
Other	648	25	647	24
NHS Charitable funds: Other resources expended			875	490
TOTAL	347,755	338,742	348,633	339,235

Note 5 Employee Expenses				
Note 5.1 Employee Expenses breakdown				
	Foundation Trust		Group	
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Salaries and wages	174,521	171,004	174,521	171,004
Social security costs	12,819	12,881	12,819	12,881
Pension costs - defined contribution plans Employers contributions to NHS Pensions	21,540	21,582	21,540	21,582
Pension cost - other	-	-	-	-
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	526	-	526
Agency/contract staff	14,312	13,248	14,312	13,248
NHS Charitable funds staff	-	-	-	-
TOTAL	223,192	219,241	223,192	219,241
Costs capitalised as part of assets	1,712	801	1,712	801
included within:				
Analysed into Operating Expenditure				
Employee Expenses - Staff	220,543	217,020	220,543	217,020
Employee Expenses - Executive directors	937	894	937	894
Research & development	-	-	-	-
Redundancy	-	526	-	526
Early retirements	-	-	-	-
Special Payments	-	-	-	-
NHS Charitable funds: Employee expenses	-	-	-	-
Total Employee benefits excluding capitalised costs	221,480	218,440	221,480	218,440
Note 5.2 Average number of employees (Whole Time Equivalent basis)				
	2014/15	2013/14	2014/15	2013/14
	Number	Number	Number	Number
Medical and dental	527	529	527	529
Administration and estates	1,241	1,213	1,241	1,213
Healthcare assistants and other support staff	1,190	1,039	1,190	1,039
Nursing, midwifery and health visiting staff	1,666	1,614	1,666	1,614
Scientific, therapeutic and technical staff	556	681	556	681
Agency and contract staff	185	163	185	163
Bank staff	114	126	114	126
TOTAL	5,479	5,365	5,479	5,365
Note 5.3 Directors' remuneration				
The aggregate amounts payable to directors were:	2014/15	2013/14		
	£'000	£'000		
Salary	991	937		
Taxable benefits	15	9		
Employer's pension contributions	139	113		
Total	1145	1059		
Note 5.4 Employee benefits				
Note 5.5 Early retirements due to ill health				
	2014/15	2013/14	2014/15	2013/14
	Number	Number	Number	Number
No of early retirements on the grounds of ill health	10	7	10	7
	2014/15	2013/14	2014/15	2013/14
	£000	£000	£000	£000
Value of early retirements on the grounds of ill health	550	355	550	355

Note 5.6 Staff exit packages						
	2014/15	2014/15	2014/15	2013/14	2013/14	2013/14
Exit package cost band 2014/15:	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
< £10,000	-	32	32	1	-	1
£10,000 - £25,000	-	49	49	2	1	3
£25,001 - £50,000	-	47	47	2	3	5
£50,001 - £100,000	-	10	10	2	-	2
£100,001 - £150,000	-	1	1	1	-	1
£150,001 - £200,000	-	1	1	-	-	-
Total number of exit packages by type	-	140	140	8	4	12
Total resource cost	-	3,302	3,302	387	139	526
Note 5.7 Exit packages: other (non-compulsory) departure payments 2014/15						
	2014/15	2014/15		2013/14	2013/14	
	Payments agreed	Total value of agreements		Payments agreed	Total value of agreements	
	Number	£000		Number	£000	
Voluntary redundancies including early retirement contractual costs	88	2,238		0	0	
Mutually agreed resignations (MARS) contractual costs	51	1,038		4	139	
Early retirements in the efficiency of the service contractual costs	0	0		0	0	
Contractual payments in lieu of notice	1	26		0	0	
Total	140	3,302		4	139	
of which:						
non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary						
<p>The Trust is part of a final salary scheme which is included in note 5. They operated the 'Mutually Approved Resignation Scheme' (MARS) & 'Voluntary Redundancy Scheme' (VRS) for one hundred and forty individuals in 2014/15. The principles of MARS & VRS were based on the nationally agreed scheme and applies the principles agreed by the NHS Staff Council for local schemes. The MARS is a scheme under which an individual employee, in agreement with their employer, chooses to leave employment in return for a severance payment. A mutually agreed resignation is not a redundancy or a voluntary redundancy. The scheme was agreed with staff side representatives on the Trust's Staff Management Partnership Forum.</p>						
Note 5.8 Pension Costs						
<p>Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.</p> <p>In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FRoM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:</p>						
a) Accounting valuation						
<p>A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2015, is based on valuation data as 31 March 2014, updated to 31 March 2015 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FRoM interpretations, and the discount rate prescribed by HM Treasury have also been used.</p> <p>The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.</p>						
b) Full actuarial (funding) valuation						
<p>The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.</p> <p>The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.</p> <p>The Scheme Regulations allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.</p>						
c) Scheme provisions						
<p>The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:</p> <p>The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.</p> <p>With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".</p> <p>Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).</p> <p>Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.</p> <p>For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.</p> <p>Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.</p>						

Note 6 Operating expenses - miscellaneous		
Note 6.1 Operating leases		
	2014/15	2013/14
	£000	£000
Minimum lease payments	4,672	4,327
Less sublease payments received	(6)	(6)
TOTAL	4,666	4,321
Note 6.2 Arrangements containing an operating lease		
	2014/15	2013/14
	£000	£000
Future minimum lease payments due on buildings:		
- not later than one year;	1,314	724
- later than one year and not later than five years;	5,110	2,218
- later than five years.	19,438	6,065
TOTAL	25,862	9,007
Future minimum lease payments due on plant & Machinery:		
- not later than one year;	1,807	1,888
- later than one year and not later than five years;	3,730	4,185
- later than five years.	301	423
TOTAL	5,838	6,496
Future minimum lease payments due on other leases:		
- not later than one year;	110	286
- later than one year and not later than five years;	48	164
- later than five years.	-	17
TOTAL	158	467
There are no lease payments due on land		
Total of future minimum sublease lease payments to be received as the balance sheet date	68	44
Note 6.3 Late Payment		
There were no amounts included within 'Interest payable' arising from claims made under the Late Payment of Commercial Debts (Interest) Act 1998 or any compensation paid to cover debt recovery costs under this legislation.		
Note 6.4 Audit Remuneration		
	2014/15	2013/14
	£000	£000
Audit services- statutory audit *	62	93
Audit services -regulatory reporting	12	12
TOTAL	74	105
* Charitable Funds audit costs of £3,480 2014/15 and £3,480 2013/14 is included within the Audit services - statutory audit figure.		
Note 7 Discontinued operations		
The Trust had no discontinued operations to disclose in 2014/15 or 2013/14.		
Note 8 Corporation Tax		
The Trust has assessed that it is not liable for Corporation tax in 2014/15 or 2013/14.		

Note 9 Finance income					
	Foundation Trust			Group	
	2014/15	2013/14	2014/15	2013/14	
	£000	£000	£000	£000	
PFI revenue	-	-	-	-	
Interest on bank accounts	91	96	91	96	
NHS Charitable funds: investment income	-	-	7	42	
TOTAL	91	96	98	138	
Note 10 Finance costs - interest expense					
	2014/15	2013/14	2014/15	2013/14	
	£000	£000	£000	£000	
Loans from the Foundation Trust Financing Facility	70	41	70	41	
Finance Costs in PFI obligations					
Main Finance Costs	6,964	7,076	6,964	7,076	
Contingent Finance Costs	3,965	3,670	3,965	3,670	
TOTAL	10,999	10,787	10,999	10,787	
Note 11 Impairment of assets					
	2014/15	2013/14	2014/15	2013/14	
	£000	£000	£000	£000	
Impairments charged to operating surplus / deficit:					
Changes in market price	1,684	2,048	1,684	2,048	
Impairments charged to the revaluation reserve	7,980	23,839	7,980	23,839	
TOTAL	9,664	25,887	9,664	25,887	

Note 13 Property, plant and equipment (Group)										
Note 13.1 Property, plant and equipment	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2014	241,754	39,896	148,918	2,101	1,968	25,612	70	21,646	1,543	-
Additions - purchased	22,442	-	7,981	-	3,270	3,116	-	7,720	355	-
Impairments charged to the revaluation reserve	(7,980)	(660)	(7,266)	(54)	-	-	-	-	-	-
Reclassifications	-	-	949	-	(949)	-	-	-	-	-
Revaluations	3,091	100	2,928	63	-	-	-	-	-	-
Disposals	(2,168)	-	-	-	(809)	(1,359)	-	-	-	-
Valuation/Gross cost at 31 March 2015	257,139	39,336	153,510	2,110	3,480	27,369	70	29,366	1,898	-
Accumulated depreciation at 1 April 2014	32,595	-	-	-	-	19,240	70	11,864	1,421	-
Provided during the year	9,107	-	5,006	54	-	2,014	-	1,995	38	-
Impairments charged to operating expenses	2,000	-	2,000	-	-	-	-	-	-	-
Reversal of impairments credited to operating income	(316)	-	(316)	-	-	-	-	-	-	-
Revaluations	(6,744)	-	(6,690)	(54)	-	-	-	-	-	-
Disposals	(1,237)	-	-	-	-	(1,237)	-	-	-	-
Accumulated depreciation at 31 March 2015	35,405	-	-	-	-	20,017	70	13,859	1,459	-
Note 13.2 Property, plant and equipment	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2013	242,875	41,190	155,929	2,912	433	24,892	70	15,944	1,505	-
Additions - purchased	15,139	-	5,854	-	1,685	1,971	-	5,591	38	-
Impairments charged to operating expenses	-	(1,944)	1,969	(25)	-	-	-	-	-	-
Impairments charged to the revaluation reserve*	(23,839)	(145)	(23,193)	(501)	-	-	-	-	-	-
Reclassifications	-	-	34	-	(150)	5	-	111	-	-
Revaluations*	9,983	1,520	8,325	138	-	-	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	(1,148)	(725)	-	(423)	-	-	-	-	-	-
Disposals	(1,256)	-	-	-	-	(1,256)	-	-	-	-
Valuation/Gross cost at 31 March 2014	241,754	39,896	148,918	2,101	1,968	25,612	70	21,646	1,543	-
Accumulated depreciation at 1 April 2013	42,112	145	11,310	406	-	18,487	70	10,333	1,361	-
Provided during the year	10,457	-	6,931	95	-	1,840	-	1,531	60	-
Impairments charged to operating expenses	2,983	-	2,983	-	-	-	-	-	-	-
Reversal of impairments credited to operating income	(935)	-	(935)	-	-	-	-	-	-	-
Revaluations*	(20,935)	(145)	(20,289)	(501)	-	-	-	-	-	-
Disposals / derecognition	(1,087)	-	-	-	-	(1,087)	-	-	-	-
Accumulated depreciation at 31 March 2014	32,595	-	-	-	-	19,240	70	11,864	1,421	-

Note 13.2 Property, plant and equipment financing	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	NHS Charitable fund assets
	£000	£000	£000		£000	£000	£000	£000	£000	£000
Net book value - 31 March 2015										
Owned	139,184	38,660	72,017	2,110	3,480	7,009	-	15,469	439	-
Finance Leased	717	676	-	-	-	41	-	-	-	-
On-balance-sheet PFI contracts and other service concession arrangements	80,451	-	80,451	-	-	-	-	-	-	-
Donated	1,382	-	1,042	-	-	302	-	38	-	-
NBV total at 31 March 2015	221,734	39,336	153,510	2,110	3,480	7,352	-	15,507	439	-
Net book value - 31 March 2014										
Owned	126,606	39,220	67,532	2,101	1,871	6,012	-	9,748	122	-
Finance Leased	730	676	-	-	-	54	-	-	-	-
On-balance-sheet PFI contracts and other service concession arrangements	80,758	-	80,661	-	97	-	-	-	-	-
Donated	1,065	-	725	-	-	306	-	34	-	-
NBV total at 31 March 2014	209,159	39,896	148,918	2,101	1,968	6,372	-	9,782	122	-

Note 13.3 Economic life of property, plant and equipment	Min Life	Max Life				
	Years	Years				
Land	-	-				
Buildings excluding dwellings	15	80				
Dwellings	15	80				
Plant & Machinery	5	15				
Transport Equipment	7	7				
Information Technology	5	8				
Furniture & Fittings	5	10				
Note 13.4 Revaluation Reserve Movements						
2014/15	Total Revaluation Reserve	Revaluation Reserve -intangibles	£000	£000	£000	Revaluation reserve - investment property
	£000	£000	£000	£000	£000	£000
Revaluation reserve at 1 April 2014	35,308	-	35,308	-	-	-
At start of period for new FTs	-	-	-	-	-	-
Impairments	-7,980	-	-7,980	-	-	-
Revaluations	9,835	-	9,835	-	-	-
Other reserve movements	-536	-	-536	-	-	-
Revaluation reserve at 31 March 2015	36,627	0	36,627	0	0	0

* The figures for 13/14 have been restated for revaluations and impairments to take in to the account the rolling up the accumulated depreciation on land Building and Dwellings in to the Gross Cost. There is no effect on the Net Book Value of the assets.

Note 14 Additions on consolidation of NHS Charities										
Note 14.1 - Reclassification of PPE additions on consolidation of NHS charities	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Purchased additions in 2014/15										
Additions - purchased by Trust	21,972	-	7,660	-	3,270	2,982	-	7,705	355	
Additions - donated of cash by charity to purchase assets	470	-	321	-	-	134	-	15	-	
Purchased additions in 2013/14										
Additions - purchased by Trust	15,038	-	5,849	-	1,685	1,900	-	5,566	38	
Additions - donated of cash by charity to purchase assets	101	-	5	-	-	71	-	25	-	
Note 14.2 - Reclassification of Intangible additions on consolidation of NHS charities	Total	Software licences (purchased)	Licences & trademarks (purchased)	Patents (purchased)	Information technology (internally generated)	Development expenditure (internally generated)	Other (purchased)	Other (internally generated)	Goodwill	Intangible Assets Under Construction
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Purchased additions in 2014/15										
Additions - purchased by Trust	502	-	-	-	502	-	-	-	-	-
Purchased additions in 2013/14										
Additions - purchased by Trust	720	-	-	-	720	-	-	-	-	-

Note 14.3 Investments - 2014/15	Investment Property*	Investments in associates (and joined controlled operations)	Other Investments**	NHS Charitable funds: Investment property	NHS Charitable funds: Other investments
		£000	£000	£000	£000
Carrying value at 01 April 2014	-	-	-	-	0
Merger adjustments	-	-	-	-	2,614
Carrying value at 01 April 2014 (restated)	-	-	-	-	2,614
At start of period for new FTs	-	-	-	-	0
Fair value gains [taken to I&E]	-	211	-	-	0
Fair value losses (impairment)	-	1,142	-	-	0
Disposals	-	-	-	-	(273)
Carrying value at 31 March 2015	0	1,353	0	0	2,341
Note 14.4 Investments - 2013/14	Investment Property*	Investments in associates (and joined controlled operations)	Other Investments**	NHS Charitable funds: Investment property	NHS Charitable funds: Other investments
	£000	£000	£000	£000	£000
Carrying value at 01 April 2013	-	-	-	-	2,602
Impairments	-	-	-	-	12
Carrying value at 31 March 2014	-	-	-	-	2,614

Note 15 Assets held for sale								
Note 15.1 Non-current assets for sale and assets in disposal groups - 2014/15	Foundation Trust Total	Group Total		Intangible assets	Property, Plant and Equipment - Land	PPE: Dwellings	Financial Investments	NHS Charitable fund assets held for sale
	£000	£000		£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2014	-	-		-	-	-	-	-
Plus assets classified as available for sale in the year	-	-		-	-	-	-	-
Less assets sold in year	-	-		-	-	-	-	-
Less Impairment of assets held for sale	-	-		-	-	-	-	-
Plus Reversal of impairment of assets held for sale	-	-		-	-	-	-	-
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	-		-	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March 2015	-	-		-	-	-	-	-
Note 15.2 Non-current assets for sale and assets in disposal groups 2013/14	Foundation Trust Total	Group Total		Intangible assets	Property, Plant and Equipment - Land	PPE: Dwellings	Financial Investments	NHS Charitable fund assets held for sale
	£000	£000		£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 13	939	939		-	380	559	-	-
Plus assets classified as available for sale in the year	1,148	1,148		-	725	423	-	-
Less assets sold in year	(2,087)	(2,087)		-	(1,105)	(982)	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March 2014	-	-		-	-	-	-	-

There are no non-current assets held for sale in 2014/15.

Note 16 Inventories				
Note 16.1 Inventories	Foundation Trust			
	31 March 2015	31 March 2014		
	£000	£000		
Drugs	2,224	1,709		
Work in progress	369	293		
Consumables	3,380	3,685		
TOTAL Inventories	5,973	5,687		
Note 16.2 Breakdown of inventories recognised in expenses	31 March 2015			
	£000			
Total inventories consumed	57,403			
Charged to:				
Drugs inventories consumed	28,752			
Supplies and services - clinical	25,614			
Supplies and services - non clinical	2,787			
Transport (other)	250			
TOTAL	57,403			
Note 17 Trade and other receivables				
Note 17.1 Trade receivables and other receivables				
	Foundation Trust		Group	
	Total		Total	
	31 March 2015	31 March 2014	31 March 2015	31 March 2014
	£000	£000	£000	£000
Current				
NHS Receivables - Revenue	6,301	8,310	6,301	8,310
Provision for impaired receivables	(933)	(1,897)	(933)	(1,897)
Prepayments (Non-PFI)	2,037	2,216	2,037	2,216
Accrued income	2,265	1,426	2,265	1,426
PDC dividend receivable	80	117	80	117
VAT receivable	1,198	1,225	1,198	1,225
Other receivables - Revenue	2,800	3,580	2,800	3,532
Other receivables - Capital	68	-	68	-
NHS Charitable funds: Trade and other receivables			12	20
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	13,816	14,977	13,828	14,949
Non-Current				
Provision for impaired receivables	(402)	(392)	(402)	(392)
Other receivables - Revenue	1,593	1,547	1,593	1,547
Other receivables - Capital	1,611	925	1,611	925
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	2,802	2,080	2,802	2,080

NHS Receivables falling due within one year includes £2,564,225 for incomplete spells of care provided at 31 March 2015 (£2,656,225 at 31 March 2014).

Note 17.2 Provision for impairment of receivables		
	2014/15	2013/14
	£000	£000
At 1 April as previously stated	2,289	1,477
Prior period adjustments*	0	0
Merger adjustments	0	0
At 1 April (restated)	2,289	1,477
At start of period for new FTs	0	0
Increase in provision	401	1,422
Amounts utilised	(625)	(10)
Unused amounts reversed	(730)	(600)
At 31 Mar / 31 Mar	1,335	2,289
Note 17.3 Analysis of impaired receivables		
	2014/15	2013/14
	£000	£000
Ageing of impaired receivables		
0 - 30 days	141	223
30-60 Days	12	14
60-90 days	18	39
90- 180 days (was "In three to six months")	372	664
180-360 days (was "Over six months")	792	1,349
Total	1,335	2,289
Ageing of non-impaired receivables past their due date		
0 - 30 days	1,561	1,768
30-60 Days	666	454
60-90 days	217	438
90- 180 days (was "In three to six months")	400	1,217
180-360 days (was "Over six months")	2,041	2,171
Total	4,885	6,048
Note 17.4 Finance lease receivables		
The Trust had no Finance lease receivables in 2014/15 or 2013/14.		

Note 20 Borrowings					
	Foundation Trust		Group		
	Tuesday, March 31, 2015	Monday, March 31, 2014	Tuesday, March 31, 2015	Monday, March 31, 2014	
	£000	£000	£000	£000	
Current					
Capital loans from Department of Health	500	-	500	-	
Obligations under finance leases	-	25	-	25	
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,497	1,424	1,497	1,424	
TOTAL CURRENT BORROWINGS	1,997	1,449	1,997	1,449	
Non-current					
Loans from Independent Trust Financing Facility	7,000	-	7,000	-	
Capital loans from Department of Health	1,550	1,050	1,550	1,050	
Obligations under PFI, LIFT or other service concession contracts	78,895	80,390	78,895	80,390	
TOTAL OTHER NON CURRENT LIABILITIES	87,445	81,440	87,445	81,440	

Note 21 Prudential borrowing

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been replaced with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

Note 22 Other liabilities				
	Foundation Trust		Group	
	Tuesday, March 31, 2015	Monday, March 31, 2014	Tuesday, March 31, 2015	Monday, March 31, 2014
	£000	£000	£000	£000
Current				
Deferred income - grants	-	-	-	-
Deferred income - goods and services	1,069	1,053	1,069	1,053
Deferred income - rent of land	-	-	-	-
Other deferred income	97	97	97	97
Deferred PFI credits	-	-	-	-
Lease incentives	-	-	-	-
NHS Charitable funds: other liabilities	-	-	-	-
TOTAL OTHER CURRENT LIABILITIES	1,166	1,150	1,166	1,150
Non-current				
Deferred income - grants	-	-	-	-
Deferred income - goods and services	-	-	-	-
Deferred income - rent of land	-	-	-	-
Other deferred income	1,450	1,546	1,450	1,546
Deferred PFI credits	-	-	-	-
Lease incentives	-	-	-	-
NHS Charitable funds: other liabilities	-	-	-	-
TOTAL OTHER NON CURRENT LIABILITIES	1,450	1,546	1,450	1,546
Note 22.1 Other Financial Liabilities	Tuesday, March 31, 2015	Monday, March 31, 2014	Tuesday, March 31, 2015	Monday, March 31, 2014
	£'000	£'000	£'000	£'000
Non-current				
Derivative and embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial liabilities	-	-	-	-
NHS Charitable funds: other financial liabilities	-	-	-	-
Total	-	-	-	-
Current				
Derivative and embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial liabilities	-	-	-	-
NHS Charitable funds: other charitable funds	-	-	-	-
Total	-	-	-	-

Note 23 Provisions and contingent liabilities											
Note 23.1 Provisions for liabilities and charges											
	Foundation Trust				Group						
	Current		Non-current		Current		Non-current				
	Tuesday, March 31, 2015	Monday, March 31, 2014	Tuesday, March 31, 2015	Monday, March 31, 2014	Tuesday, March 31, 2015	Monday, March 31, 2014	Tuesday, March 31, 2015	Monday, March 31, 2014			
	£000	£000	£000	£000	£000	£000	£000	£000			
Pensions relating to former directors	-	-	-	-	-	-	-	-			
Pensions relating to other staff	477	249	1,188	1,640	477	249	1,188	1,640			
Other legal claims	171	63	(1)	(0)	171	63	(1)	(0)			
Agenda for Change	-	-	-	-	-	-	-	-			
Restructurings	2,050	1,663	(1)	-	2,050	1,663	(1)	-			
Continuing care	-	-	-	-	-	-	-	-			
Equal pay	-	-	-	-	-	-	-	-			
Redundancy	-	-	-	-	-	-	-	-			
Other	694	1,151	1,218	1,166	694	1,151	1,218	1,166			
NHS Charitable fund provisions					-	-	-	-			
Total	3,392	3,126	2,404	2,806	3,392	3,126	2,404	2,806			
Note 23.2 Provisions for liabilities and charges analysis	Foundation Trust Total		Group Total		Pensions - former directors	Pensions - other staff	Other legal claims	Re-structurings	Redundancy	Other *	NHS charitable fund provisions
	£000		£000		£000	£000	£000	£000	£000	£000	£000
At 1 April 2014	5,932		5,932		-	1,889	63	1,664	-	2,316	-
Arising during the year	3,164		3,164		-	-	141	2,439	-	584	-
Utilised during the year - accruals	(2,176)		(2,176)		-	(270)	(33)	(1,242)	-	(631)	-
Reversed unused	(1,193)		(1,193)		-	-	-	(810)	-	(383)	-
Unwinding of discount	69		69		-	45	-	-	-	25	-
At March 2015	5,796		5,796		-	1,664	171	2,050	-	1,911	-
Expected timing of cashflows:											
- not later than one year;	3,392		3,392		-	477	171	2,050	-	694	-
- later than one year and not later than five years;	1,826		1,826		-	888	-	-	-	938	-
- later than five years.	578		578		-	299	-	-	-	279	-
TOTAL	5,796		5,796		-	1,664	171	2,050	-	1,911	-
*The total value of Other Provisions of £1.911m all relate to provisions which are less than £1m.											
Note 23.3 Clinical Negligence liabilities											
			Tuesday, March 31, 2015	Monday, March 31, 2014							
			£000	£000							
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Calderdale and Huddersfield NHS Foundation Trust.			91,053	73,234							
Note 23.4 Contingent (Liabilities) / Assets											
There were no contingent liabilities or assets to disclose at 31 March 2015 or 31 March 2014.											

Note 24 Related Party Transactions		
The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24.		
Monitor have directed, through the Annual Reporting Manual 2014/15, that all bodies within the scope of 'Whole of Government Accounts' (WGA) are related parties. Accordingly, the table below details material transactions.		
Related party transactions - WGA organisations	2014/15	2013/14
	£000	£000
Income - NHS Calderdale CCG	138,767	137,677
Income - NHS Greater Huddersfield CCG	126,619	126,801
Income - NHS North Kirklees CCG	5,276	5,223
Income - NHS Bradford Districts CCG	6,753	6,939
Income - NHS Wakefield CCG	979	936
Income - Leeds Teaching Hospitals NHS Trust	1,053	1,897
Income - South West Yorkshire Partnership NHS Foundation Trust	5,468	4,906
Income - South Yorkshire and Bassetlaw Area Team	18,889	17,184
Income - Health Education England	9,407	8,603
Income - West Yorkshire Area Team	9,371	7,666
Income - Other WGA	22,982	25,979
Income - Total with WGA organisations	345,564	343,811
Expenditure - Bradford Teaching Hospitals NHS Foundation Trust	682	1,076
Expenditure - Leeds Teaching Hospitals NHS Trust	1,519	1,526
Expenditure - NHS Pension Scheme	21,540	21,518
Expenditure - NHS Litigation Authority	7,561	6,915
Expenditure - HMRC	12,819	13,795
Expenditure - Other WGA	6,385	5,925
Expenditure - Total with WGA organisations	50,506	50,755
Related party balances - WGA organisations	31 March 2015	31 March 2014
	£000	£000
Receivables - NHS Calderdale CCG	2,136	2,629
Receivables - NHS Greater Huddersfield CCG	1,591	1,214
Receivables - NHS England	1,214	1,613
Receivables - HM Revenue & Customs - VAT	1,198	1,225
Receivables - Other WGA	3,527	4,449
Receivables - Total with WGA organisations	9,666	11,130
Payables - NHS Pension Scheme	2,956	2,989
Payables - HMRC	4,062	4,162
Payables - NHS England	1,937	162
Payables - Other WGA	1,805	2,289
Payables - Total with WGA organisations	10,760	9,602

During the year, the following Board Members or members of the key management staff have declared the following interest or parties related to them.

A Haigh ~ Chair - is a Non Executive Director of Furness Building Society.

D Anderson ~ Non Executive Director - is a partner in Grange Group Practice Fartown, a Director of Prime Health Huddersfield Ltd, Grange Prime Health Ltd, Synergy P Ltd, Greater Huddersfield CCG and is a Member of Kirklees GP Consortium.

J Pease ~ Non Executive Director - is a Director Of Jeremy Pease Associates Ltd.

J Wilson ~ Non Executive Director - is a Director of Groundwork Wakefield Limited, Job Match (UK) Ltd and Whitwood Golf Club Castleford, holds a contract for service with Yorkshire & Humber Postgraduate Deanery and South West Yorkshire Partnership FT.

L Patterson ~ Non Executive Director - is a Director and sole owner of Dr Linda Patterson Ltd, Chair of Medical Specialties Expert group, Patient Safety NHS England, Chair of CQC inspections and holds a contract for service with Consultancy Health care Improvement in NHS, PricewaterhouseCoopers LLP.

P Oldfield ~ Non Executive Director - is a Director of Sue Ryder and Director and Owner of Tanzuk Consulting.

Prof P Roberts ~ Non Executive Director - is a Director of Pennie Property Partnership LLP, Partner of Catchweasel, Chair of First Ark group, Non Executive Director of Genisis Housing, Vice Chair of Northern Ireland Housing Executive and is Chair of Planning Exchange foundation.

K Griffiths ~ Director of Finance - Is a Director of Pennie Property Partnership LLP.

L Hill ~ Director of Planning, Performance and Estates & Facilities - is a Director of Pennie Property Partnership LLP, and a Trustee of Dean Clough Foundation.

D Birkenhead ~ Medical Director - is a Trustee of Children's Forget Me Not Trust.

O Williams ~ Chief Executive - is a Trustee of the NHS Confederation.

In 14/15 there were transactions between Calderdale & Huddersfield NHS Foundation Trust and related parties, additional to those declared under the scope of Whole of Government accounts.

The expenditure between the Trust and Pennie Property Partnership LLP in 14/15 was £598,000.

The expenditure between the Trust and PricewaterhouseCoopers LLP in 14/15 was £608,000.

The expenditure between the Trust and NHS Confederation in 14/15 was £10,209.

The Trust had income from Forget Me Not Trust in 14/15 of £1,976.

The Trust had income from Grange Group Practice Fartown in 14/15 of £100.

Note 25.1 Joint Venture

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This partnership is the Pennine Property Partnership LLP and is owned 50/50 by the Trust and Henry Boot Development Ltd.

It has developed a new 56,000 sq ft healthcare facility following the exchange of a pre-let agreement, with the Trust to operate the building.

The development has involved the substantial reconstruction and refurbishment of an existing derelict stone mill, known as Acre Mill, and now provides a range of modern outpatient facilities. The facility has been in use since end of January 2015.

The Pennine Property Partnership LLP's principal place of business is within the UK.

The Trust has used the equity accounting method.

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

The JV has no capital commitments.

	Tuesday, March 31, 2015	Monday, March 31, 2014
Disclosure of aggregate amounts for assets and liabilities of jointly controlled operations	£000	£000
Non current assets	10,702	3,041
Current assets	1,142	876
Total assets	11,844	3,917
Current liabilities	(9,467)	(4,085)
Non current liabilities	(2,377)	168
Total liabilities	(11,844)	(3,917)
Operating income	528	-
Operating expenses	(38)	(40)
Fair Value revaluation Gain	2,283	-
Surplus /(deficit) for the year	2,773	(40)

Note 26 Contractual Capital Commitments

	Tuesday, March 31, 2015	Monday, March 31, 2014
	£000	£000
Property, Plant and Equipment	12,107	589
Intangible assets	-	-
Total	12,107	589

Note 26.1 Finance lease obligations

	Tuesday, March 31, 2015	Monday, March 31, 2014
Gross lease liabilities	-	-
of which liabilities are due		
- not later than one year;	-	25
- later than one year and not later than five years;	-	-
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	-	25
- not later than one year;	-	25
- later than one year and not later than five years;	-	-
- later than five years.	-	-
All Finance Lease obligations are for Plant & Machinery.		

Note 27 PFI (on Statement of Financial Position)		
Note 27.1 PFI obligations (on Statement of Financial Position)		
	Tuesday, March 31, 2015	Monday, March 31, 2014
	£000	£000
Gross PFI liabilities	289,908	306,164
of which liabilities are due		
- not later than one year;	12,392	12,382
- later than one year and not later than five years;	50,453	50,596
- later than five years.	227,063	243,186
Finance charges allocated to future periods	(209,516)	(224,350)
Net PFI obligation	80,392	81,814
- not later than one year;	1,497	1,424
- later than one year and not later than five years;	6,194	5,992
- later than five years.	72,701	74,398
Note 27.2 On-SoFP PFI commitments in respect of the service element of the PFI		
	Tuesday, March 31, 2015	Monday, March 31, 2014
	£000	£000
Commitments		
Within one year	11,144	11,022
2nd to 5th years (inclusive)	46,849	46,338
later than five years.	152,269	165,789
	210,262	223,149
The PFI scheme above relates to Calderdale Royal Hospital. The PFI contractor is Calderdale Hospitals SPC Ltd (formerly Catalyst Healthcare Ltd). The Trust are responsible for the provision of all clinical services, Calderdale Hospitals SPC Ltd provide fully serviced hospital accommodation.		
Note 28 Other Financial Commitments		
Other financial commitments	Tuesday, March 31, 2015	
	£000	
not later than 1 year	931	
after 1 year and not later than 5 years	8,763	
paid thereafter	10,671	
Total	20,365	
This commitment relates to a contract with Cerner Ltd to deliver an Electronic Patient Record system and includes costs relating to Bradford Teaching Hospital NHS Foundation Trust. The contractual commitment remains with Calderdale & Huddersfield NHS Foundation Trust as the contract signatory.		
Calderdale & Huddersfield NHS Foundation Trust has a back to back legal agreement with Bradford Teaching Hospital NHS Foundation Trust to indemnify Calderdale & Huddersfield NHS Foundation Trust against any associated risk.		

Note 29 Financial assets and financial liabilities				
Note 29.1 Financial assets by category				
		Foundation Trust		Group
		Total		Total
		£000		£000
Assets as per Statement of Financial Position				
Trade and other receivables excluding non financial assets (at 31 March 2015)		7,771		7,771
Cash and cash equivalents at bank and in hand (at 31 March 2015)		13,697		13,697
Total at 31 March 2015		21,468		21,468
Trade and other receivables excluding non financial assets (at 31 March 2014)		9,655		9,655
Cash and cash equivalents (at bank and in hand (at 31 March 2014)		22,840		22,840
Total at 31 March 2014		32,495		32,495
All financial assets at 31 March 2015 and 31 March 2014 were classified as loans and receivables. The Trust had no financial assets held at fair value through Income and expenditure, Held to maturity or Available-for-sale.				
Note 29.2 Financial liabilities by category				
		Total		Total
		£000		£000
Liabilities as per Statement of Financial Position				
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2015)		9,050		9,050
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2015)		80,392		80,392
Trade and other payables excluding non financial liabilities (at 31 March 2015)		31,785		31,785
Total at 31 March 2015		121,227		121,227
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2014)		1,050		1,050
Obligations under finance leases (31 March 2014)		25		25
Obligations under PFI, LIFT and other service concession contracts (31 March 2014)		81,814		81,814
Trade and other payables excluding non financial liabilities (31 March 2014)		30,767		30,767
Total at 31 March 2014		113,656		113,656
All financial liabilities at 31 March 2015 and 31 March 2014 were classed as other financial liabilities. The Trust had no liabilities held at fair value through income and expenditure.				
Note 29.3 Maturity of Financial liabilities				
	31 March 2015	31 March 2014		
	£000	£000		
In one year or less	33,782	32,215		
In more than one year but not more than two years	2,904	1,996		
In more than two years but not more than five years	6,839	5,046		
In more than five years	77,702	74,399		
Total	121,227	113,656		

Note 29.4 Fair values of financial assets at 31 March 2015				
	Foundation Trust		Group	
	Book Value	Fair value	Book Value	Fair value
	£000	£000	£000	£000
Other Investments	1,142	1,142	1,142	1,142
Total	1,142	1,142	1,142	1,142
Note 29.5 Fair values of financial liabilities at 31 March 2015				
	Foundation Trust		Group	
	Book Value	Fair value	Book Value	Fair value
	£000	£000	£000	£000
Loans	9,050	9,050	9,050	9,050
Total	9,050	9,050	9,050	9,050

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

Note 29.6 Financial Instruments

Financial risk management

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust neither buys or sells financial instruments. The NHS Foundation Trust has limited powers or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Board of Directors has approved a Treasury Management policy which sets out the parameters for investing any surplus operating cash in short-term deposits. This includes the restriction of any such investment to permitted institutions with appropriate credit ratings; these ratings are in line with the guidance issued by Monitor 'Managing Operating Cash in NHS Foundation Trusts'. In addition the policy sets out the maximum limits for any such investments. The policy, and its implementation are reviewed by the Audit & Risk Committee and the Board of Directors. The Trust's treasury management activity is subject to review by the Trust's internal auditors.

Interest rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust receives cash each month based on an annually agreed level of contract activity with in-year adjustments to reflect actual levels of income due.

The Trust has withdrawn its working capital facility, which the Trust never utilised, based on a change in guidance from Monitor.

In 2014/15 the Trust has financed part of its capital expenditure from internally generated funds and externally from Independent Trust Financing Facility (ITFF). In the prior year the Trust has financed its capital expenditure from internally generated funds.

The Trust is not, therefore, exposed to significant liquidity risk.

Currency risk

The Trust is principally a domestic organisation with negligible transactions, assets and liabilities in foreign currencies. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Note 30 Health Informatics

The Trust provides information management and technology services to a number of other NHS Organisations from the Health Informatics Service. The income and expenditure of the service are included in the Statement of Comprehensive Income; and the value of income in 2014/15 was £5,789,000 (£6,771,000 in 2013/14).

Note 31 Limitation on Auditors Liability

There is £1m limit on our external Auditors liability.

Note 32 Losses and special payments

Note 32.1 Losses and special payments

There were 67 cases of losses and special payments totalling £99,000 during the period covered by these accounts (115 cases totalling £108,000 in 2013/14).

There were no clinical negligence cases where the net payment exceeded £100,000.

There were no fraud cases where the net payment exceeded £100,000.

There were no personal injury cases where the net payment exceeded £100,000.

There were no compensation under legal obligation cases where the net payment exceeded £100,000.

There were no fruitless payment cases where the net payment exceeded £100,000.

Note 32.2 Recovered Losses

The Trust has not received any compensation payments from CHCC.

Note 33 Events after the reporting period

There are no disclosable events after the reporting period.

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