NHS

Calderdale and Huddersfield

NHS Foundation Trust

Annual Report and Accounts 2016/17

compassionate care

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts

2016/17

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

Contents

Cover picture
Community Staff Nurses Anne King and Natalie Rhodes.

Introduction

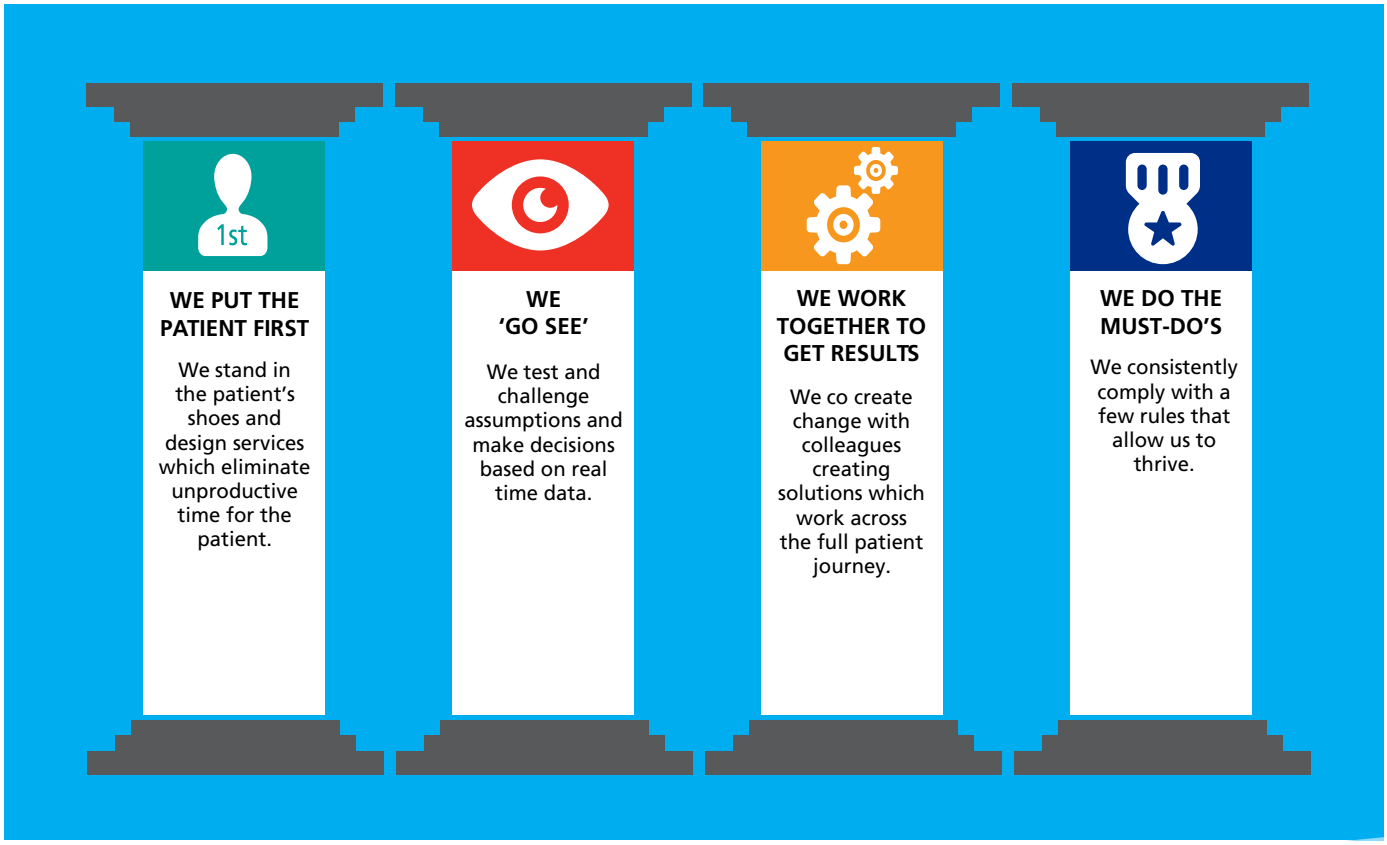
Introduction

Our vision and values

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

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

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



Chairman's statement

One thing I have learned as Chair of the Trust is that it never stands still in its pursuit to improve services for the populations of Greater Huddersfield and Calderdale. And this year is no exception. We have recently delivered the single biggest transformation undertaken by the Trust; our move to an Electronic Patient Record (EPR).

Training started back in March and we made the switchover from old fashioned paper files at the bottom of the patient's bed to digitally stored information in May. It was a huge undertaking affecting thousands of CHFT colleagues.

This significant transformation puts our Trust at the vanguard of technology-advanced trusts in the country. I am a very proud chairman to be able to report that is it already delivering improvements for our patients and their families.

Your doctor, nurse or therapist can log on with their secure passwords and see all aspects of your healthcare. There's no having to ask a patient and their families the same questions at different steps along their care. The answers are there and can be easily accessed on a computer. That record stays put, unlike the files which had to follow the patient around, so less time is spent hunting them down and more time is spent providing care.

And this is just the start. It will take many years to complete fully but what a start we have made. It takes us truly into the 21st century as a healthcare provider.

Of course, it is very much in support of our frontline care providers. It can't replace a smile and compassion when it comes to delivering NHS care.. This Trust never loses sight of that. We are in the top 20% of Trusts in the country for recognising the contribution our staff make to improving care in this year's annual NHS Staff Survey.

The Chairman signs up a new member

We are very much aware of how our staff go above and beyond for our patients. Every month we recognise them through our Star Award. They are nominated by their colleagues on the frontline, which makes it extra special. We are now in the second year of the award, entries are increasing all the time and nominations have come from every role we have at the Trust: doctors, nurses, therapists, midwives, porters, administrators and a theatre technician who was so good a new mum named her baby after him. The baby is called Stan.

2017 will also be big year for another reason. We expect to finalise our Full Business Case about how healthcare will be provided by us in our hospitals and community into the future. This will prompt more debate – which is an expected and essential part of the process – as it brings us nearer to the new vision for healthcare locally. Our GP partners in the clinical commissioning groups will then decide on next steps. Watch this space.

For me 2016-17 was the year we all worked together to bring about big change and I thank the Membership Councillors and Board members for all their support throughout and anticipation of more of the same going forward – my 7th and last year as Chairman.

I would also like to thank our fabulous volunteers who freely give their time to make a real difference every day to our patients, greeting them with a smile and being a point of support and reassurance for anyone who visits our hospitals.

I would also like to end on a light-hearted note and thank this Stormtrooper for supporting our Trust's very successful campaign to promote organ donation to save and enhance lives. Our team had a very enjoyable, sunny day at Syngenta's Family Fun Day attracting huge interest and more names to the donor register.

So, thanks to him and, more importantly, to everyone here at CHFT delivering care 24/7 365 days a year for our patients and their families.

It is a pleasure and honour to be Chairman here and I look forward to the year ahead.

Regards

Andrew Haigh
Chairman


NHS

Performance Report

Overview of performance

Statement from the Chief Executive

2016-17 has been dominated by the NHS's well-publicised struggle to cope with soaring number of patient attendances at emergency departments.It really was a winter that challenged us – as all Trusts – to the very core.

It also took a huge amount of working together here at CHFT to continue to provide compassionate care in such challenging conditions.

How an emergency department is performing is always the headline grabber. Yet an emergency department can't function properly if colleagues inside the hospitals are struggling to find beds on the wards for patients who need admitting for care. And they can't function without our partners in social care working with us to help with discharges back into a family home or into nursing and care homes.

Last winter was the perfect example of how, when the going gets tough, the NHS pulls together inside and outside of hospitals to deliver against the odds.

We were amongst the top 10 trusts for our emergency care four hour wait performance throughout the winter period. It is no surprise to me that my 6,000 colleagues not only kept everything going, they did a terrific job and worked together to ensure our patients and their families received the care they deserved. Our Trust was named by the Health Service Journal as among the Top 50 trusts in the country. And that was for the second year running.

All this is great news, yet we know we have room for improvement. The CQC inspectors visited us in March last year and though many areas were rated 'good' we received an overall rating of 'requires improvement'. They highlighted areas where we could improve and we have implemented all of their recommendations and more besides. My frontline colleagues know where we can get better and how we can do it and we listen to them!

So, our team at CHFT is very much looking forward to the upcoming year and all the changes it will bring. We've already brought in EPR as my colleague, chairman Andrew Haigh, has outlined in his statement in this Annual Report.

And there will be more challenges to come which we face with positivity.

Here at CHFT, we will continue to work together to provide compassionate care for every patient and their families into the future.

Owen Williams, Chief Executive

Our purpose and activities

The principal purpose of the Trust is the provision of goods and services for the purpose of health care in England. The principal location of business of the Trust is:

- Trust Headquarters, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, West Yorkshire HD3 3EA

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

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

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

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

In 2016/17 Calderdale and Huddersfield NHS Foundation Trust cared for more than 120,000 men, women and children as inpatients (stayed at least one night) or day cases and more than 459,000 people attended our outpatient clinics.

Our A&E departments at both hospitals saw and treated more than 151,000 people.

There were some 310,000 adult services contacts by our community teams as well as 266,000 contacts with our therapy services.

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

A brief history

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

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

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

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

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

In 2015 the Trust won the tender to provide sexual health services in Calderdale in a joint bid with the Calderdale GP Federation. We continue to work with partners in both Calderdale and Huddersfield to develop and deliver high quality, compassionate health care services for our patients.

In March 2016, the two local Clinical Commissioning Groups in Calderdale and Greater Huddersfield announced a 14 week formal public consultation on the reconfiguration of hospital services. The proposals include centralising emergency care on the Calderdale Royal Hospital site and creating a new planned care centre on the Acre Mills site in Huddersfield. Both sites would have an urgent care centre and a birth centre. The consultation finished on 21 June 2016 and the Clinical Commissioning Groups agreed to move to full business case. The Trust and the CCGs are developing the full business case which is due for approval by the Boards in July for submission to NHS Improvement. The whole process is subject to scrutiny by the Joint Local Authority Overview and Scrutiny Committee.

Key issues and risks

The Trust continued to strengthen its risk management processes during 2016/17 with the development and approval of a risk management strategy and risk appetite statement. There is a regular review of the Board Assurance Framework and the high level risk register at the Board and its sub-committees. A description of the principle risks and uncertainties facing the Trust is set out in the Annual Governance Statement on p87.

In May 2016, the Board of Directors agreed the annual plan – setting out the key areas of delivery for year two of the five year plan. The plan aims to achieve the Trust vision of 'Together we will deliver outstanding compassionate care to the communities we serve' and is built around the four goals of the Trust:

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

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

Transforming and improving patient care

- Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI.
- Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, cost improvement programme, Care Quality Commission preparation and service reconfiguration) while keeping the base safe.
- Failure to progress service reconfiguration caused by an inability to agree a way forward across health and social care partners.
- Inability to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.
- Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care.
- Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust.

Keeping the base safe

- Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety.
- Failure to implement robust governance systems and processes across the Trust.
- The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvement.
- Failure to achieve local and national performance targets.
- Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care.

A workforce fit for the future

- Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
- Failure to attract and develop appropriate clinical leadership across the Trust.
- Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.

Financial sustainability

- Failure to deliver the financial forecast position for 2016/17 due to non-delivery of cost improvement programmes, reduced activity and increased expenditure on additional capacity.
- Failure to develop a robust financial plan for 2017/18 including identification of cost improvement programmes.
- Failure to maintain cash flow.

The management and mitigation of these risks is reported to the Board each month. More information on the Trust's risk management arrangements is included in the Annual Governance Statement on p87.

Additional challenges

The two local Clinical Commissioning Groups undertook formal public consultation on proposals to reconfigure hospitals services to address some of these challenges. There is a significant risk to the Trust if reconfiguration is not supported in terms of delivery of safe services, recruitment and retention of staff and financial sustainability.

At the time of writing this report, the Trust is implementing an electronic patient record across the whole organisation, in partnership with Bradford Teaching Hospitals NHS Foundation Trust (BTHFT). Over 80% of Trust staff were trained prior to go live and 100% of standard operating procedures were written and signed off. As would be expected with a change programme of this size, the implementation has led to a number of challenges including user access; reporting of information; patient flow and a reduction in the number of clinics. There is a command and control structure in place to ensure that these risks and any potential clinical risks are identified and managed.

The Trust underwent its first full Care Quality Commission inspection in March 2016. The Trust received an overall rating of 'requires improvement' with 19 must do and 12 should do actions to be completed. As at the time of writing this

report, the Trust had not received its follow-up inspection. In the intervening period, the Care Quality Commission have announced changes to their inspection regime. The Trust is considering what the impact of these changes may be and how it can be assured that it meets the required standards across all areas.

Financial sustainability

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

The Trust has used its 2016/17 financial performance to model the plan for 2017/18 and 2018/19 alongside the activity forecasts and capacity requirements for its services and is planning for the following income and expenditure position:

- Underlying deficit of £46m;
- Non recurrent support from centrally allocated Sustainability and Transformation Fund to be received at £10.1m, contingent upon achieving performance measures;
- Cost improvement programme savings delivery at £20m. This is above the nationally required level, recognising the need to cover specific financial pressures and reduce the Trust's deficit;
- Planned deficit position of £15.9m.

The Trust is also planning to continue to invest in transformational capital technology and estate schemes in 2017/18. The total capital expenditure being planned is £14.4m.

As described above, the Trust is reliant upon external cash support in order to continue to operate. The total borrowing requirement in 2017/18 will be £28.8m to cover the day to day running of services as represented by the revenue position and the capital investment programme. Of this £8m is being funded by way of a pre-approved capital expenditure loan from the Independent Trust Financing Facility (ITFF) to support the continued investment in the EPR system. The remaining £20.8m is to be secured through further ITFF borrowing.

A particular risk exists non-recurrently in 2017/18 with regard to the implementation of the EPR system which is being implemented in the first quarter of the year and as such costs span across late 2016/17 into 2017/18. This drives a short term financial pressure through loss in clinical productivity and therefore income during the testing and implementation phase and the need to release and backfill staff for training. This is based on experience of other providers implementing a similar system. The Trust continues to explore mitigations to this position.

The plan is mindful of the work in support of the West Yorkshire and Harrogate Sustainability and Transformation Plan and West Yorkshire Association of Acute Trusts collaborative. New models of service delivery working with partners will be developed to deliver sustainable services in the future. The next two years is the start of the service reconfiguration journey for the Trust which aims to support CHFT's strategic objectives, delivering benefits for patients, staff, the Trust and the local health economy.

Going Concern

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

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

The Trust Board has assessed various sources of information in order to assess whether it is appropriate to prepare the accounts on a going concern basis. These include both internal and external reporting, the trust's long term financial plan, audit reports and dialogue with NHS Improvement. The Trust has closed the year with a cash balance of £1.941m and positive net assets of £86m.

However, given the challenge within the financial plans for 2017/18, further areas require consideration to be able to demonstrate that the Trust is a going concern.
The following has been taken into account when going concern is considered:

- The unaudited year-end financial position of £14.99m deficit (excluding exceptional items as described in note to the SOCI) was in line with the planned deficit of £16.1m. Whilst still a deficit position; this secures a level of confidence from NHS Improvement in the Trusts ability to deliver plans.
- The Trust closed the year with £1.941m of cash but cannot sustain the planned deficit position within 2017/18 without the requirements of external cash support. As such, the Trust has been in communication with NHS Improvement to arrange for loan facilities to enable the Trust to operate throughout 2017/18. With this borrowing in place, the Trust will be able to meet its liabilities.
- The commissioners continue to commission services from the Trust and contracts with commissioners have been agreed and were signed in February 2017. This leads to regular monthly transfers of fixed levels of cash based on contracted values for 2017/18. This incoming cash along with the loan facility will allow the Trust to meet all its obligations and liabilities.
- From Internal Audit reports completed in 2016/17 there have been no other indications of significant financial risk or weaknesses in financial risk management
- Throughout 2016/17 the Trust has continued to work closely with local partners to develop a long term strategy and consult with the public on future plans. The Trust is continuing to work upon service transformation plans aided by reconfiguration to deliver a sustainable long term future. This strategy has been supported by regulators.
- In 2016/17 the cost improvement programme challenge of £14m was exceeded by £0.98m. A project management office is in place and the PMO methodology ensures that the cost improvement programme plans for 2017/18 are robust and oversees their delivery. 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. Delivery of the 2017/18 financial plan requires an efficiency saving of £20m. This is not yet fully identified.

In conclusion the Trust does not have any evidence to suggest that the going concern basis is not appropriate. There is a reasonable expectation that Calderdale and Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.

Performance Analysis

How we measure performance

Like all Trusts, Calderdale and Huddersfield NHS Foundation Trust is under enormous pressure to meet the health care needs of a growing and diverse population, alongside great changes to the infrastructure of the NHS and a difficult financial climate. The Trust provides hospital services to both Calderdale and Greater Huddersfield and community services in Calderdale. The Trust's performance against a range of national targets and standards is assessed and reported externally. These measures include the 4-hour emergency care standard; cancer referral targets; infection control standards; 18-week waiting times and staffing levels.

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

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

The Board also considers a quarterly update on progress against the key strategic objectives identified in the Trust's One Year plan (see p24).

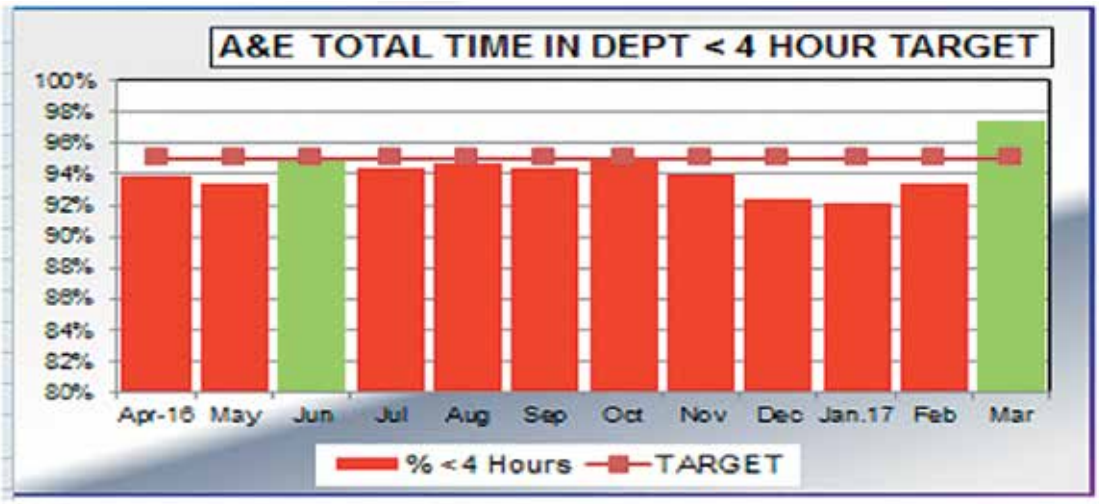
Our performance

The Trust has continued to deliver a strong performance across all its targets for 2016/17 in the face of significant challenges. The Trust provided safe, compassionate care for all of its patients with a high level of patient satisfaction, while continuing to achieve the demanding efficiency savings and financial balance.

Indicator	Target	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
Total time in ED under 4hrs	95%	94.1%	94.5%	93.7%	94.4%
Referral to Treatment Time, 18 wks. in aggregate, Incomplete pathways	92%	96.4%	96.1%	95.6%	95.1%
Cancer 2 week wait (all)	93%	97.0%	98.0%	97.9%	97.5%
Cancer 2 week wait Breast Symptomatic	93%	93.6%	95.0%	96.6%	96.0%
Cancer 31 days from diagnosis to first treatment	96%	99.2%	99.5%	99.7%	99.7%
Cancer 31 days for second or subsequent treatment – surgery	94%	100.0%	100.0%	98.7%	98.6%
Cancer 31 days for second or subsequent treatment – drug treatment	98%	100.0%	100.0%	100.0%	100.0%
Cancer 62 day wait for first treatment (urgent GP)	85%	91.7%	90.9%	89.9%	89.0%
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	90%	91.5%	95.5%	88.4%	88.9%

Like many other Trusts, we have had significant challenges in the Emergency Care Standard 4 hours, with A&E attendances increasing in 2016/17 by 2.5% – 3,700 on the same period in 2015/16 to **151,355** (an average of 415 attendances per day). This resulted in underperformance against this target in 2016/17.

Although the Trust missed the Emergency Care 4-hour standard it during 2016/17 it maintained its position as one of the top performing acute Trusts nationally for Emergency Care, 18 weeks Referral to Treatment and Cancer targets.

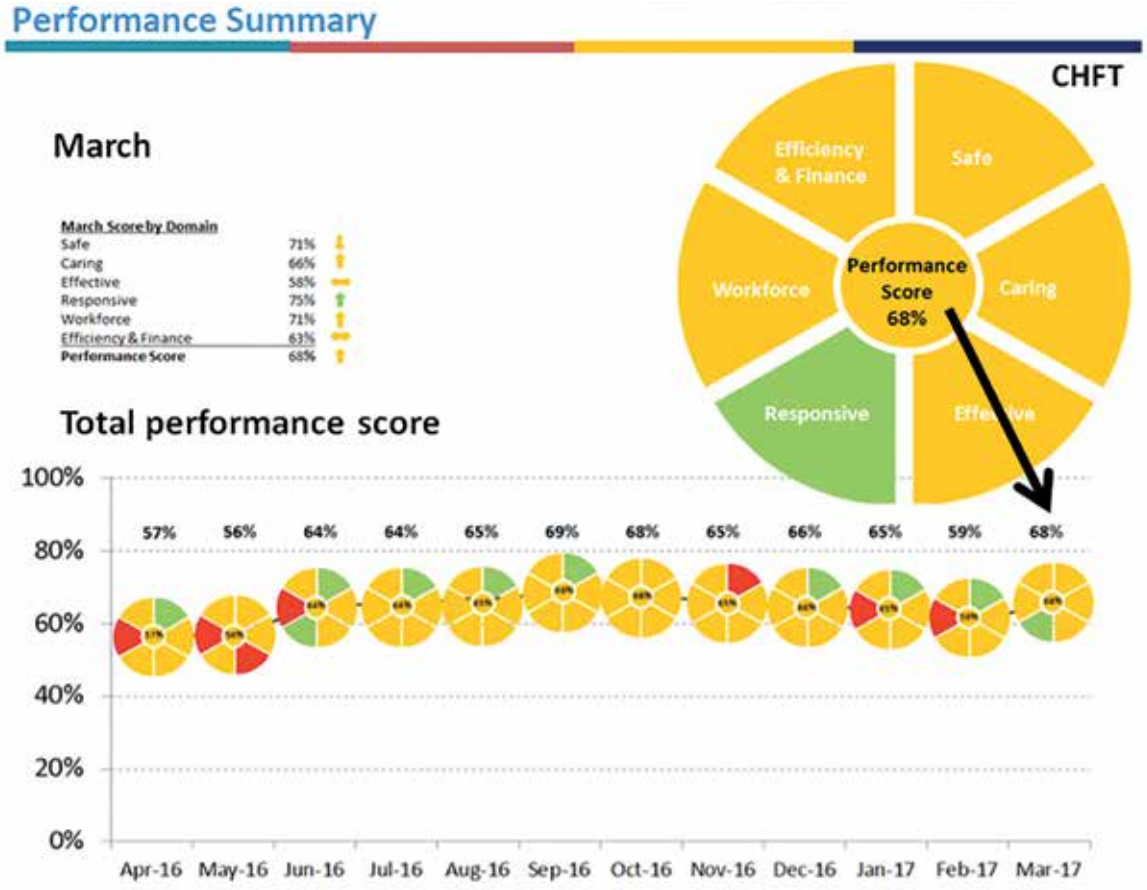


Performance Management Framework

In 2016/17 CHFT introduced a new Performance Management Framework which is now firmly embedded in the organisation with the establishment of new Integrated Performance Reports (IPRs) at Trust and Divisional level and monthly Performance Review Meetings. The IPR has brought about a greater degree of transparency and accountability across the organisation.

This year the Trust implemented a scoring system for performance. Each performance target is given a score based on its RAG rating and then some key targets are weighted more heavily.The scores for the targets in each of the six domains (safe, caring, effective, responsive, well-led and finance) are then combined to get a percentage score and a threshold applied to give the overall rating: < 50% is **red**, 50% to < 75% is **amber** and 75% and above is **green**. The overall performance score is calculated by adding up the scores for all domains, dividing by the maximum total score possible for all domains to get a percentage and then applying the same thresholds to RAG rate the overall score.

Below is the Performance Summary taken from the March 2017 IPR which shows a split by domain of Trust performance during 2016/17.



Performance against our strategic objectives

In May 2016, the Board of Directors agreed the One Year Plan and quality priorities for 2016/17. The plan described the four goals of the Trust:

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

These goals are underpinned by our four behaviours:

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

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

Year Ending 2017				
Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	Subject to consultation, develop DoH approved implementation plans for the 5 Year Strategic Plan. Deliver on YE 2017 including strengthening community services for 2017	Undertake a Well Led Governance Peer Review and implement any actions to support the findings and ensure ongoing compliance with NHS Improvement & CQC	Develop and implement a 5 year workforce and organisational development plan	Deliver a robust financial plan including CIP for YE 2017
	Refocus the Care of the Acutely Ill Patient action plan and implement the SAFER (patient flow) and hospital@night programmes to improve quality of care	Implement the actions resulting from the findings from the CQC inspection	Implement the colleague produced action plan in response to Investor in People accreditation; the staff survey; Friends and Family Test and Workforce Race Equality Scheme	Working with partners, including across WY, develop and implement a sustainability and transformation plan including Carter compliance
	To work as an early adopter toward the implementation of selected 7 day NHS England standards (2,5,6 and 8)	Implement year 2 of the health and safety action plan and via the estates strategy, deliver against level B quality standards	Design and deliver a leadership and succession planning development programme	Develop a full CIP programme for YE 2021
	Together with our partners deliver and implement a robust EPR system	Implement the local quality priorities (see separate page)	Delivery of the integration of finance and workforce information systems ensuring consistency of provision and integrity of data	Develop a 5 year commercial strategy for THIS and consolidate the existing PMU strategy

The Board received a report on progress against each of these areas on a quarterly basis throughout 2016/17. At the year end, of the 16 deliverables one had been fully delivered – implementation of the well led governance review action plan; 13 were on track but had not been completed by the year end; and there were two areas with significant work outstanding:

- The organisational development plan for the Trust requires further work prior to approval. It is articulated at a high level in the Workforce Strategy and supporting action plan. A paper on the National Improvement and Leadership Development Board's framework, Developing People – Improving Care was presented to the Trust's Executive Board in February. Further work is being done to look at how this fits with the Trust's leadership development arrangements and complete the organisational development plan by summer 2017.

- The Trust's workforce related IT systems - including ESR, e-rostering, e-rostering for medics and job planning – require review. A workforce modernisation board has been set up to co-ordinate this work and will report monthly to the Workforce Well Led Committee.

Care Quality Commission Inspection

The Trust received its first Care Quality Commission (CQC) Chief Inspector of Hospitals inspection between 8th and 11th March 2016 as part of their comprehensive inspection programme. In addition, unannounced inspections were carried out on 16th and 22nd March 2016.

The overall rating for the Trust was 'requires improvement'.

Final ratings for the Trust

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

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

These reports included a narrative to support the judgements that were made for each of the key questions and included a list of actions that the Trust must do take to improve quality and safety of care, and a further list of actions that the Trust should take.

The CQC gave the Trust a good rating for care and responsiveness in both hospitals and requires improvement in the other core areas of effectiveness, well-led and safety. Our community services received a good rating in all the areas.

Breaking down the service by service rating more than 70% received a good rating. The CQC inspectors highlighted some areas of outstanding practice including:

- The development and growth of the ambulatory care service
- Use of engagement support workers to engage and socialise as well as providing cognitive and physical support to patients with dementia and/ or delirium
- Development of recognising deteriorating patients and Nerve Centre technology to support identification and escalation of deteriorating patients
- A proactive and energised discharge team

The inspection team gave special mention to staff who spoke with pride and passion about working for the Trust.
The inspection team also provided positive feedback about

- infection control policies and practice
- the patient's ability to access suitable nutrition and hydration including special diets
- a positive incident reporting culture; and
- adherence to duty of candour principles.

The report set out 19 must do actions and 12 should do actions. Some of these were detailed as requirement notices that cross referenced to 3 CQC regulations.

The requirement notices were in relation to:
Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
- Regulation 12 (1) Care and treatment must be provided in a safe way for service users
Regulation 17 HSCA (RA) Regulations 2014 Good governance
- Regulation 17 (1) Systems and processes must be established and operated effectively to:
(2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services.
Regulation 18 HSCA (RA) Regulations 2014 Staffing
- Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.
- Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

The Trust put in place an action plan to address the must do and should do actions detailed in the final report. Some of these impacted on all divisions. Others were specific to a core service and an individual division. Each division also had individual improvement and sustainability plans to address the issues raised in the core service reports and the actions required to ensure services sustained the good practice observed at the time of the CQC inspection.

Examples of improvements that have been made so far:

- Governance processes have been strengthened at Divisional and ward level with increased support from the corporate Risk and Governance Team and more robust quality and assurance arrangements at ward and department level. A particular focus has been to maximise learning from adverse events, with colleague engagement events held to appreciate preferred methods of learning and to identify the current barriers to learning. (Well Led)
- The Trust's approach to improved staffing has been strengthened with a number of initiatives introduced to increase staffing in both the nursing and medical workforce. (Well Led, Safe, Effective)
- A significant improvement has been achieved in the timeliness of complaint responses (Well Led, Effective)
- Maternity services have strengthened their approach to receiving and responding to feedback from women, greater engagement with service users is seen as key to the success of this (Safe, Caring, Effective)

Well-Led Governance Review

During 2016/17 the Trust completed all of the actions identified through its independently assessed Well-led Governance Review. The review produced five green/amber scores meaning that there were some elements of good practice identified with some minor omissions. There were also five amber/red scores meaning that there were some elements of good practice and no major omissions, however the action plans to address the gaps were in an early stage of development with limited evidence.

Some of the key areas of delivery from the review have been:

- Strengthened risk management arrangements from Board to Ward
- More robust performance management with the revised performance report and divisional performance boards
- Strengthened serious incident and incident reporting and investigation.
- Improved data quality assurance.
- More detailed clinical audit reporting and review.
- Additional medical leadership arrangements.
- Board to ward visits and reporting.

Sustainability and sustainable development

In 2016/17 the Trust has continued to implement measures to reduce its environmental impact, A Sustainable Development Group including executive and non-executive directors oversees the Sustainable Development Action Plan. The Plan is used to target specific areas within the broader sustainable development agenda such as recycling and more sustainable travel and socio-economic concerns.

Dry mixed recycling compactors have been introduced to both main hospital sites, which will allow greater volumes of recycling to occur. These are already having a positive impact on the levels of recycling in the Trust and the subsequent cost of waste disposal. Waste training has moved to an e-learning package including recycling.

The local greengrocers stall at Huddersfield Royal Infirmary is providing an increased service on three days a week, giving a more sustainable option for staff and visitors than pre-packaged supermarket fruit and vegetables. Links to the wider public health agenda are made through regular meetings with the Local Authorities.

Energy usage continues to be a priority for the Trust with the continued roll out of LED lighting to replace less efficient fluorescent tubes.

Social and Community Issues

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

The Trust works with a number of local schools and colleges offering work experience and placement opportunities. 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 2017 the Trust employs around 60 apprentices, with plans to double this during 2017/18. The Trust is also working towards a year on year increase in staff under the age of 25. The Trust has also formed links with key community and voluntary sector organisations including Calderdale Deaf Society and HealthWatch.

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

We have a number of policies in place which cover social, community and human rights matters. A process is in place to ensure that none of our policies have an adverse or discriminatory effect on patients or staff. We continue to provide positive support to people with a disability who wish to secure employment with the Trust through the Guaranteed Interview scheme and comply with two ticks requirements. There are policies in place which support staff who may become disabled during their employment.

Important events since the end of the financial year 2016/17

Our new Electronic Patient Record
During 2016/17 we prepared for the implementation of a new electronic patient record in line with the NHS commitment that by 2020 all electronic health records would be fully interoperable and patient records would be paperless. The system went live over the weekend of 28 April – 1 May 2017.

The EPR uses the Cerner Millennium solution with an aim to create a patient centric comprehensive clinical record that will improve care quality, clinical safety and outcomes and is being implemented jointly with Bradford Teaching Hospitals NHS Foundation Trust.

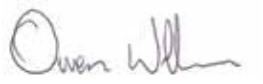
The system builds on a number of tactical solutions already implemented by the Trust including Nervecentre (e-observations system), Athena (our maternity patient record system), Bluespier (the theatres system) and community mobile.

The EPR will encourage standardised ways of working. This has the potential to reduce the length of stay for our patients. It will also allow our community staff to access records from wherever they are to one 'single source of truth'. EPR will empower staff to work more effectively so patients benefit from improved quality and experience.

Overseas operations

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

Signed



Owen Williams
Chief Executive
23 May 2017

Accountability Report

Directors' Report

Composition of the Board of Directors

The members of the Board during 2016/17 were:

- Andrew Haigh – Chairman
- Owen Williams – Chief Executive

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

- Dr David Anderson – Non-Executive Director and Senior Independent Director
- Karen Heaton – Non-Executive Director and Chair of Workforce Well-Led Committee
- Richard Hopkin – Non-Executive Director
- Phil Oldfield – Non-Executive Director and Chair of the Finance and Performance Committee
- Dr Linda Patterson – Non-Executive Director and Chair of the Quality Committee
- Professor Peter Roberts – Non-Executive Director and Chair of the Audit and Risk Committee
- Jan Wilson – Non-Executive Director and Deputy Chair

The Board has also included two additional non-voting Directors:

- Anna Basford – Director of Transformation and Partnerships
- Mandy Griffin – Director of the Health Informatics Service

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

- Keith Griffiths – Executive Director of Finance – resigned 28.10.16
- Gary Boothby - Executive Director of Finance – appointed 1.11.16
- Brendan Brown - Executive Director of Nursing – appointed 13.6.16
- Ian Warren - Executive Director of Workforce and Organisational Development – appointed 1.8.16

The gender balance of the Board as at 31 March 2017 was:

	Female	Male
Non-Executive Directors	3	5
Executive Directors	2	5
Non-voting Directors	2	0

The age profile of the Board as at 31 March 2017 was:

Age	Number of directors
18-39	0
40-49	2
50-59	10
60-69	4
70+	1

Meetings of the Board of Directors

The Board of Directors met 11 times during 2016/17 including the Annual General Meeting.

NAME OF DIRECTOR	BOARD OF DIRECTOR MEETINGS ATTENDED
A Haigh (Chair)	10/11
D Anderson	09/11
K Heaton	09/11
R Hopkin	10/11
P Oldfield	08/11
L Patterson	07/07 (Sabbatical leave January -Sept 2016)
P Roberts	10/11
J Wilson	11/11
O Williams	10/11
H Barker	11/11
D Birkenhead	09/11
G Boothby	06/06 (appointed 1.11.16)
B Brown	08/09 (appointed 13.6.16)
K Griffiths	05/05 (resigned 28.10.16)
L Hill	09/11
I Warren	07/07 (appointed 1.8.16)

Appraisal of Board members

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

The Chairman undertakes the performance review of Non-Executive Directors using the Trust's appraisal documentation and the outcomes of these appraisals are reported to the Membership Council. During 2016-17, 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 is then reported to the Council by the Senior Independent Non-Executive Director.

Biographies of the Board of Directors

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

Andrew Haigh
Chairman

Appointment: July 2011 to July 2018
Andrew was appointed as Chairman of the Trust in July 2011. He trained locally as a chartered accountant with Armitage & Norton and moved to KPMG in Leeds when the two firms merged in 1987. He specialised in IT risk management and audit, particularly within retail financial services and the public sector eventually leading the IT Advisory practice for the KPMG in the UK and the Financial Services practice in the North of England. He became a Non-Executive Director of the Trust in December 2010. He is also a Non-Executive Director at Furness Building Society in Barrow. Andrew has lived in Huddersfield all his life.

Owen Williams
Chief Executive

Appointed: May 2012
Owen, aged 48, has been the Chief Executive of Calderdale and Huddersfield NHS Foundation Trust (CHFT) since May 2012. This represents his third Chief Executive role across Local Government and the NHS during a career which has spanned both the public and private sectors. He is also a Trustee of the NHS Confederation, a national body that brings together, and speaks on behalf of, the whole health and care system. He is passionate about providing compassionate care built on CHFT's four pillars of putting the patient first; going to see; working together to get results and doing the must do's. Owen believes that diversity of leadership and greater colleague engagement are essential to meeting increased expectations regarding the quality of care and patient safety, together with the reality of significant gaps in the financial resources available.

Brendan Brown
Executive Director of Nursing/Deputy Chief Executive

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

Gary Boothby
Executive Director of Finance

Appointed: November 2016
Gary Boothby has been Finance Director since November 2016. Previously he was the Deputy Director of Finance from March 2016. Gary joined the Trust from the Mid Yorkshire Hospitals NHS Trust where he had been the Deputy Director of Finance. Mr Boothby joined the NHS as a finance trainee following his graduation from the University of Humberside where he studied Accounting and Finance, and then went on to become a Chartered Management Accountant in 1996 whilst at Burnley Healthcare NHS Trust. A large part of his career has been in senior divisional finance roles at both Mid Yorkshire Hospitals NHS Trust and at Pennine Acute Hospitals where there was a strong track record of working closely with Divisions to deliver both patient improvements and financial efficiencies.

Lesley Hill
Executive Director of Planning, Estates and Facilities

Appointed: May 2006
Lesley has worked as a director of the Trust for eleven 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 NHS Improvement, supporting clinical divisions in the development of business plan; and is responsible for the leadership and delivery of the Estates and Facilities services on all sites, including Emergency Planning.

David Birkenhead
Executive Medical Director
Initially appointed on an interim basis in June 2014. Permanent appointment from July 2015.

David has been working in the Trust as a Consultant Microbiologist since 2000. He has held a number of senior clinical leadership roles in the Trust and was appointed to the post of Medical Director in July 2015, he continues in his role as a Consultant Microbiologist on a part time basis. 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.

Helen Barker
Chief Operating Officer
Appointed: January 2016

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

Ian Warren
Executive Director of Workforce and Organisational Development
Appointed: August 2016

Ian joined the Trust on 1st August 2016, from United Lincolnshire Hospitals NHS Trust, where he was a member of the team which successfully led the Trust out of special measures in 2015, following Sir Bruce Keogh's team inspections in July 2013. Prior to this he was the Director of HR and OD for Lincolnshire Community Health Services NHS Trust, having joined in July 2009. Prior to joining the NHS, Ian worked as a senior HR professional, and as Director of Performance within the private sector, with experience covering manufacturing, waste management and telecommunications. His experience covers all aspects of HR and Organisational Development with a focus on organisational design, employee development and process improvement. He holds an MSc in HR, and has a passion for cultural and transformational change, employee engagement and its impact on delivering excellent and consistent high quality patient care and experience.

Jan Wilson
Non-Executive Director
Appointment: December 2011 to November 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
Appointment: September 2011 to September 2018

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

Professor Peter Roberts
Non-Executive Director
Appointment: September 2011 to September 2017

Peter is Professor Emeritus of Sustainable Spatial Development at the University Of Leeds, Interim 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 activities. Peter has advised House of Commons Select Committees and to the Local Government Association. 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 Audit and Risk Committee, Chair of the Sustainable Development Group and a member of the Research, Huddersfield Pharmacy Specials and Pennine Property Partnership Committees. He is also Joint Chair of the NHS Confederation Sustainable Development Committee.

Dr Linda Patterson
Non-Executive Director
Appointment: October 2013 to September 2019

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

Philip Oldfield
Non-Executive Director
Appointment: September 2013 to September 2019

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

Register of Directors' Interests

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

Karen Heaton
Non-Executive Director
Appointment: March 2016 to March 2019

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

Richard Hopkin
Non-Executive Director
Appointment: March 2016 to March 2019

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

Committees of the Board of Directors

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

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

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

Nominations and Remuneration Committee – Chaired by Andrew Haigh

The Nominations and Remuneration Committee (Board of Directors), in setting the pay of the Executive Directors based its decisions on Department of Health guidance and available benchmarking data.

The membership of the committee was as follows:
– Andrew Haigh – Chairman
– Dr David Anderson – Non-Executive Director
– Karen Heaton – Non-Executive Director
– Richard Hopkin – Non-Executive Director
– Phil Oldfield – Non-Executive Director
– Dr Linda Patterson – Non-Executive Director
– Jan Wilson – Non-Executive Director
– Prof Peter Roberts – Non-Executive Director (for nominations items only).

During 2016/17 the Committee met on two occasions and the meetings were quorate.

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

- Review of Terms of Reference – no changes made
- Severance Payment of a Senior Manager agreed
- Appointment of Deputy Chief Executive made
- In the financial year 2016/17, 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 be no pay uplift to the Directors excluding the Director of Planning, Estates and Facilities where a 1% uplift had been agreed to reflect the additional roles and responsibilities of the post.
- It was agreed that an external review would be undertaken during 2017.

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 2016/17.

Audit and Risk Committee – Chaired by Professor Peter Roberts

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

The Audit and Risk Committee has approved terms of reference which are reviewed annually and are available on request. The membership of the Audit and Risk Committee during 2016/17 was:
– Professor Peter Roberts – Non-Executive Director and Chair of the Committee
– Phil Oldfield – Non-Executive Director
– Richard Hopkin – Non-Executive Director

The Committee was supported by a number of officers from the Trust:
– Keith Griffiths – Executive Director of Finance (until his resignation in October 2016)
– Gary Boothby – Executive Director of Finance (from November 2016)
– Victoria Pickles – Company Secretary

One Membership Councillor is also invited to attend and observe each meeting.

The Trust and the Committee are supported by the Internal Audit and Counter-fraud Service provided by Audit Yorkshire and its external auditors KPMG. If necessary, the Committee may also seek independent legal or other professional advice. The Committee met five times during 2016/17. The meeting in May specifically looks at the Annual Report and Accounts. The attendance at the Committee for the financial year 2016/17 was:

Member	Attended
Professor Peter Roberts	5/5
Phil Oldfield, Non-Executive Director	4/5
Richard Hopkin, Non-Executive Director	4/4
Dr David Anderson, Non-Executive Director (co-opted)	1/1

The principal activities of the Committee over the year were:

Financial Reporting

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

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

To aid the review, the Committee received reports from the Director of Finance and also reports from the external auditor on the outcomes of their interim and year-end audit process. The key significant risks highlighted by the external auditor in their 2016/17 plan were:

- Valuation of fixed assets
- Value for money risk given the Trust's continued breach of licence position

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

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

Governance and Risk Management

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

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

The Committee has continued to pay particular attention to the Trust's risk management arrangements and approved a Risk Management Strategy, which will be further developed during the course of the year, including a revised risk management policy. The Committee, on behalf of the Board, also led the work to develop a risk appetite statement which was approved by the Board in October and will be reviewed annually by the Audit and Risk Committee.

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

Of particular importance is the review of the disclosure statements that flow from the Trust's assurance processes with internal control weaknesses described within the Annual Governance Statement. The Committee discussed and agreed upon the disclosed areas of internal control gaps as described within the 2016/17 Annual Governance Statement.

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

- Reviewing quality governance and assurance processes
- Increasing non-executive capacity on the Committee
- Ensuring data quality and links to the performance report are considered
- Including a feedback and reflection from the meeting item is included on the agenda
- Undertaking a risk appetite assessment
- A similar exercise has been undertaken and actions from this have been identified for 2017/18.

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. The Committee regularly reviews the corporate compliance register to ensure that all areas of compliance are being managed and appropriate assurance given. During 2017, the processes for scrutiny of divisional compliance will be strengthened through the Risk and Compliance Group which reports to the Committee.

Internal Audit and Counter Fraud

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

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

The Committee agrees a defined work plan and monitors progress against this plan in addition to any specific, pro-active pieces of work that have been identified by management within the year. During 2016/17 an additional audit was requested by the Committee relating to the Trust's electronic patient record programme.

The plans as agreed for 2016/17 and the additional work programmes were completed and culminated in an annual opinion of significant assurance from the Head of Internal Audit (HOIA).

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

External Audit

The external audit service is provided by KPMG LLP (KPMG). KPMG was appointed on 1 October 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. In October 2015, it was approved by the Membership Council to extend the contract for a further two years to enable some continuity to be maintained. This contract will be re-tendered in 2017.

The Committee recognise that non-audit related services can be provided by KPMG. In order to maintain KPMG's independence, the Committee has been informed of the robust internal procedures that KPMG apply when considering the undertaking of any non-audit services. In addition to this control, any significant non-audit services would require the pre-approval of the Committee. In the year 2016/17 there were no significant non-audit related services provided by KPMG.

The Committee reviewed and approved the External Audit plan for 201617. 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 2016/17 were:

- the two significant risks mandated by International Standards for Auditing (ISAs):
  - Fraudulent Recognition of income
  - Management override of controls
- one further significant risk:
  - Valuation of Land and Buildings

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 was only one item remaining unadjusted within the financial statements. The auditor confirmed their intention to issue an unqualified audit opinion.

The fee for the audit was £56,000 (plus VAT).

Expressions of Concern, including Whistleblowing

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

Other areas of focus

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

- The Committee reviewed the clinical audit processes within the Trust and gained assurance that these are scrutinised by the Quality Committee.
- A review of the Trust's clinical negligence claims profile following an increase in premiums as the amounts paid out for clinical claims relating to the Trust exceeded the premiums paid.
- Information Governance and Records Strategy Group began formally reporting to the Committee.
- The Committee considered the conflicts of interest process and the number of declarations made across the Trust. This will be an area of focus for 2017/18 with the introduction of a new policy to meet the guidance issued by NHS England which will be effective from June 2017.


NHS

Directors' Statements

Details of political donations

The Board confirmed that no political donations have been made during the year.

Compliance with HM Treasury cost allocation and charging guidance

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

Better payment practice code

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

Income disclosure

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

Disclosure to the Auditors

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

Preparation of the Annual Report and Accounts

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

Our accounts, which begin on P185 of this document, have been prepared under a direction issued by NHS Improvement under the NHS Act 2006 (as amended by the Health and Social Care Act 2012)

Enhanced Quality Governance Reporting

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

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

Throughout the year the Trust Board received a quarterly quality report that provided detailed performance information. This information was reviewed at directorate, divisional and corporate quality meetings.
During 2016/17 the Trust completed the actions from a Well-Led Governance Review from 2015/16 with an independent external organisation which looked at both corporate and quality governance arrangements.

A significant amount of work has taken place during the year to embed and strengthen clinical governance processes within the divisions and at ward level . This has included:

- Developing governance standards for wards and departments
- Delivery of ward managers development programme covering quality, risk and governance
- Development of ward level strategies with the 10 commitments from the nursing and midwifery framework
- A refreshed exemplar ward programme to measure quality of nursing care against standards
- Improved availability of information on key performance measures at ward level for ward staff with monthly performance meetings with ward managers
- Strengthened divisional governance support from the central governance risk team and review of clinical governance support to ensure that it is proportionate to the divisional risk profile
- Development of a Trust framework for learning from complaints and incidents
- Review of divisional risk and compliance registers, with trigger alerts of new risks to the relevant management team to enable early scrutiny of risks
- Re-commencement of a ward to board assurance programme providing opportunities for relationship development, visible leadership, embedding the Trust strategy and a better understanding of patient experience.

The Trust has agreed a Risk Management Strategy during the year which confirms the Trust vision for risk management, objectives, how we embed risk management and our organisational structure for risk management, together with the supporting governance structure. This governance structure was revised during the year following a review of Board Committees which ensured that all Committee sub-groups were aligned with the relevant Committee.

More information on quality governance is included within the Annual Governance Statement on P87 and the Quality Report starting on P107.

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

Monitoring Improvements in Quality and CQC targets

The CQC carried out an inspection of the Trust in March 2016 as part of their comprehensive inspection programme, with unannounced inspections later that month. The Trust was rated as requires improvement overall.

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

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

A detailed plan was developed for each of the actions, with the delivery of the plan overseen by a CQC Response Group with regular updates from management leads against the agreed timescales. Reports on progress have been provided monthly to the Trust Executive Board, the Quality Committee and the Board of Directors. Progress has also been discussed with commissioners and the CQC Inspection Managers via regular relationship meetings.

More information on the findings of the CQC can be found on p25 and p119 of this report.

Our Patients 2016/17

Patient Experience

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

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

It is important when we measure patient experience, that patients are also given the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient and day case, as well as in the A&E and outpatient departments areas, maternity services and across community services.

Friends and Family Test

The FFT question asks *"How likely are you to recommend our ward / department to friends & family if they needed similar care or treatment?"* Performance is monitored internally against the national performance baselines during July – Sept 2016.

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

2016/7 % response rate

	2016/17 (11 month data)
Inpatient	34%
A&E	13%
Maternity	42%
Community	12%
Outpatients	12%

2016/17 % would recommend

	2016/17 (11 months data)
Inpatient	98%
A&E	89%
Maternity	97%
Community	87%
Outpatients	91%

Local Quality Improvement Projects

This year four projects were identified as priorities for quality improvement. Each of these has seen progress over the year and utilised opportunities for service user engagement at various stages. Further details are given in the Quality Account, The four projects were:

- **Children's voice** - colleagues working with children and young people were keen to create more innovative ways of involving children and young people in their healthcare and also in how services are designed and delivered, and to establish a more robust arrangement, enabling more sustainable activities to be put in place. A variety of successful approaches were taken throughout the year to maintain a culture of engagement, including a visit by the ward team to Sheffield Children's Hospital to experience a youth forum which provided some useful ideas to take this forward locally. This will be the next step towards engaging with children and young people as key stakeholders enabling them to influence decisions about services and help develop a culture of participation.

- **Effective communication on a busy surgical ward** - surveys of patients' views have revealed that patients are not always aware of their plan of care, with communication not always being as good as it could be. This project, which has commenced on general surgical ward which receives post-surgery patients is supported by the Yorkshire and Humber Improvement Academy, It further explores, via a culture survey, how communication takes place between the multidisciplinary team and how key information such as a patient's clinical condition, the treatment plan, and expected outcomes is shared with patients / relatives.

- **Maternity patient experience work** - Listening to women about their experience has been a major focus for the maternity team, led through a Maternity Patient Experience Group. It commenced with a workshop for the multidisciplinary team providing a real chance to reflect on whether individually and as a service we 'Put the Patient First'. The focus was on customer care and communication skills, and was delivered by the NHS National Performance and Advisory Group. Examples of the study day's objectives were: understanding the impact of your own behaviour on others, how to handle challenging situations and people and understanding and managing patient expectations.

A significant amount of work has been completed so far in response to feedback from women and their families. Going forward this work remains fundamental to influencing the service we want all our users to experience.

- **Community CQUIN - Introducing new measures of feedback** - this was determined as a quality priority by our membership for 2016 /17. Patient feedback in the Community only has one formal mechanism, the friends and email test, which does not always provide the detail required to really understand the issues of those areas which may be in need of improvement. A questionnaire was developed and survey undertaken for the out-patient Physiotherapy service. Following the results, which were positive, an action plan is being developed to address specific areas for improvement. A survey is also being undertaken for the Orthotics service.

National surveys

National surveys are another key source of patient feedback and during 2016 / 17, there have been two surveys published, one for adult in patients and one for cancer patients. The following high-level messages from each survey are given below.

National survey of adult inpatients 2015

Each year all acute and specialist NHS Trusts participate in a survey of adult inpatients. This year the survey was sent to 1220 patients discharged from a Calderdale Royal Hospital or Huddersfield Royal Infirmary in patient ward in July 2015, of these 552 responded, giving a response rate of 45%.

The results of the survey were published in June 2016. Scores for each question are out of ten, a higher score is better. Trust scores of each question in the survey are also compared with the range of results from all other Trusts that took part.

CHFT were reported as scoring "about the same", i.e. within the expected range compared to other Trusts for all but two of the questions. where the Trust was reported as scoring better than the majority of other Trusts for the questions:

- Were hand-wash gels available for patients and visitors to use? Scoring 9.8
- Were you given enough privacy when being examined or treated on the ward? Scoring 9.7

The Trust was also noted to have made a statistically significant increase since last year in the scores for two of the questions:

- Were you given enough privacy when being examined or treated in the A&E department? Scoring 9.1
- How clean were the toilets and bathrooms that you used in hospital? Scoring 9.0

The Trust has improved the average scores for 8 of the 11 sections in the survey, a further two remaining the same and one, overall view of care and services, dropping by 0.2. This relates to a question about patients being given / seen information on how to make a complaint. The Trust has updated leaflets and posters about complaints and distributed them across the organisation.

National Cancer Patient Experience Survey - 2016 Results

A survey of cancer patients is carried out each year with results published at both an overarching level as well as for each tumour site. These results are analysed to assess comparative performance, based on a calculation of "expected ranges". This means that Trusts are flagged as outliers only if there is statistical evidence that their scores deviate (positively or negatively) from the range of scores that would be expected for Trusts of the same size. The report for CHFT identified that for the majority of questions the Trust at an overall level scored within the expected range, with the exception of 3 questions, scoring lower for 2 questions (Q17 and Q22) and better for 1 question (Q56)

Questions which scored outside expected range

	Question	Number of respondents for this Trust	2015 Case-mix Adjusted Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	National Average Score
Clinical Nurse Specialist						
Q17	Patient given the name of the CNS who would support them through their treatment	393	84%	86%	94%	90%
Support for people with cancer						
Q22	Hospital staff gave information on getting financial help	227	47%	47%	63%	55%
Your overall NHS care						
Q56	Overall the administration of the care was very good / good	404	93%	85%	92%	89%

The Trust's lead cancer nurse is working with each cancer team to develop individual plans based on their results. Examples of actions taken for the above questions are the development of a new clinical nurse specialist leaflet to be given to patients and also a new financial leaflet to be issued via the information pack given out at the time of diagnosis.

Complaints

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

During the year we have focussed on:

- Improving the timeliness of responses for complainants, so we respond in the timescale agreed and ensuring that processes are in place to escalate any delays
- Monitoring the reasons for any re-opened complaints as an indicator of quality
- Training complaints investigators to improve the quality of responses for patients
- Identifying learning from complaints to improve services for patients – this is also a quality priority for 2017/18

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

During 2016/17 we received 574 complaints, (11 month data) of which 72% were upheld or partially upheld. There has been an 8% decrease in the number of complaints received.

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

The main themes from complaints during the year were clinical treatment and communication, consistent with the previous year and patient care.

Complainants can request an independent review of their complaint by the Parliamentary Health Service Ombudsman, which is now investigating more complaints referred to them than in previous years. During 2016/17 10 complaints (information only available for quarter 1 and quarter 2) regarding the Trust were accepted by the Ombudsman for investigation. During 2016/17 9 complaints investigations were completed; 5 complaints were upheld or partially upheld and 4 complaints were not upheld. (quarter 1 and quarter 2 information only available).

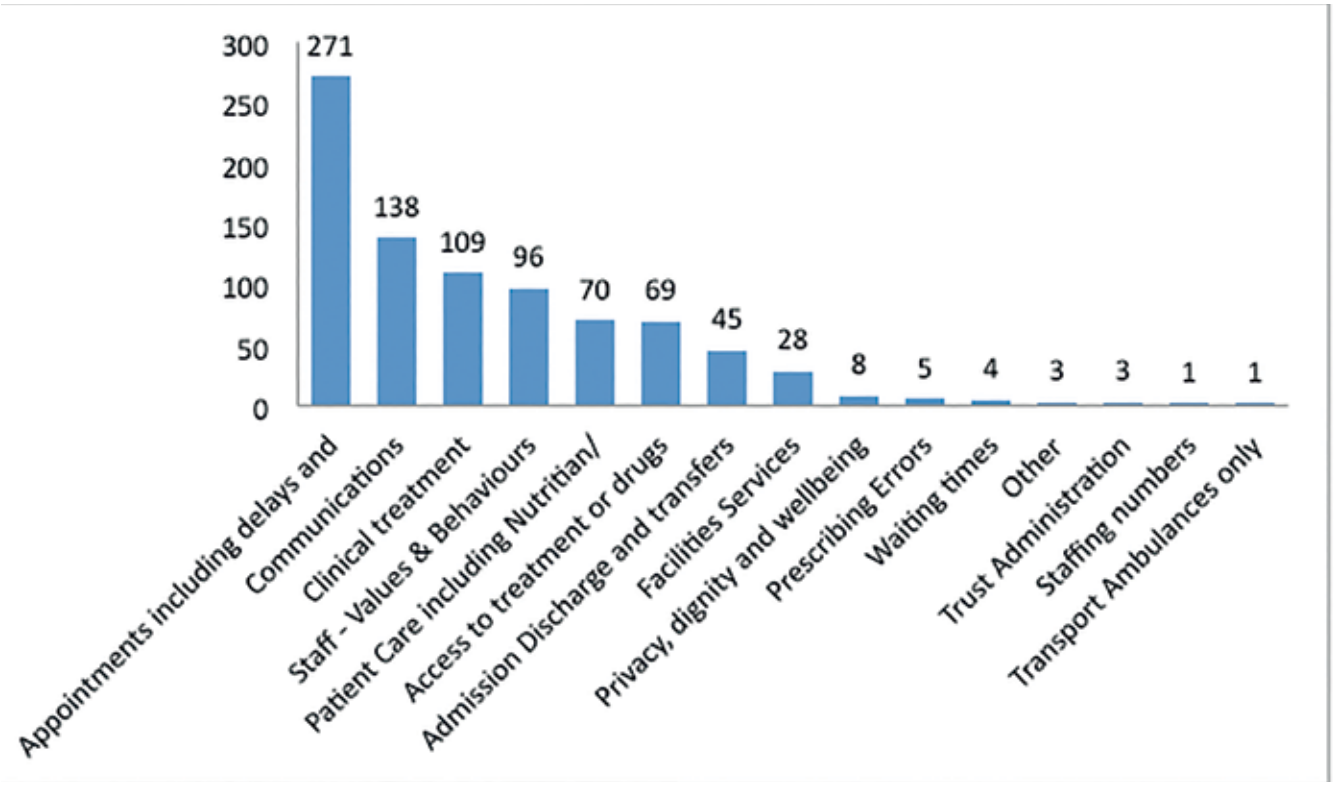
Further information on complaints is given in the Quality Account from P107.

Patient Advice and Liaison Service (PALS)

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

During 2016/17 our PALS team dealt with 883 contacts (month 11 data). There has been a 26% increase in the number of concerns received in 2016/17 compared to 2015/16. Key themes were appointments; communication and clinical treatment.

Analysis of Concerns by Theme



Compliments

In 2016/17 84 compliments (11 months data) were received centrally by the Trust. This is a small proportion of the feedback that is sent directly to teams, wards and departments across our organisation. It is always a real pleasure to see the very kind cards, letters, emails and social media posts from patients, their family and friends thanking the staff that have cared for them and giving us feedback on how our services have made a difference. We share as much of this feedback as we can through the Trust's monthly newsletter, screensavers and weekly news round up. Wherever it is possible to identify a team or individual we send the feedback directly to them.

Here are just some of the compliments received in 2016/17:

"I am writing to compliment your team following the service I have received since I was admitted through A&E at Huddersfield Infirmary, to compliment the high standard of care. I have a number of real examples that have demonstrated that the front line staff at every level are living your value of compassionate care. A real team approach. Efficient delivery of service whilst fully explaining what is happening. I have observed that all staff are making every contact count to keep patients engaged and positive. The effective team spirit and delivery in ward 17 is a credit to every individual and the clinical leadership that enables this performance to flourish. Medical and customer service was excellent consistency at every level."

"I am writing to express our appreciation of the excellent care that was given by the Trust's maternity department from start to finish at Huddersfield. It would be hard to list every person by name who was involved in our care but everyone went the extra mile to be helpful despite being extremely busy. I would say that staff are going out of their way to offer the very best possible care they can would be an understatement as they are all a credit to their departments, Trust and profession".

"During the time my father spent on your ward at Calderdale Royal Hospital he received outstanding care. All his needs were met, the staff always made sure he had a drink and would feed him and give him his drinks. He was washed and his bedding was always clean and his position was changed. Nothing was too much trouble and was kept so comfortable."

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

Stakeholder relations

The Trust works with neighbouring health and social care organisations and agencies to provide safe, high quality healthcare to our local communities. Collaborative working can also contribute to improved care delivery and access to specialist care as well as helping to address recruitment and retention challenges. An effective relationship 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 2016/17, in particular commissioners, our local authorities and the local HealthWatch organisations. This has been particularly evident in the preparation for public consultation on the reconfiguration of hospital services.

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.

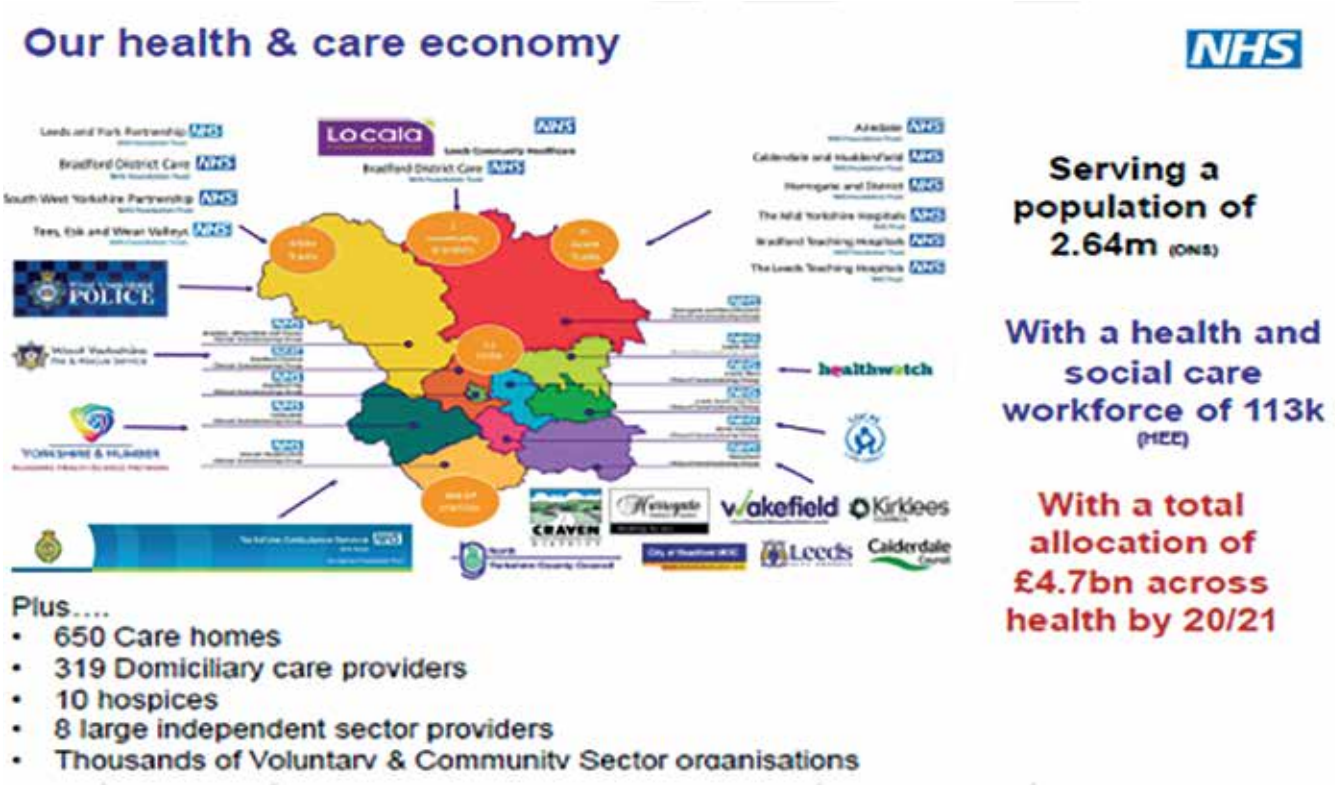
We have established stronger working relationships with the GP federations in both Calderdale and Kirklees and successfully developed services and pathways of care between primary and secondary care as a result. Our clinical leaders also worked with GP commissioners on an agreed clinical model for the future of hospital services. We have also been an active partner in the development of the Multi-Specialty Community Provider Vanguard in Calderdale alongside the Calderdale GP Federation, South West Yorkshire Partnership Foundation Trust and Locala.

We have 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.

West Yorkshire Sustainability and Transformation Plan (WYSTP) and the West Yorkshire Association of Acute Trusts (WYAAT)

West Yorkshire Sustainability and Transformation Plan (WYSTP)

During 2016/17 forty-four STP footprints were agreed nationally. CHFT has proactively undertaken work as a member of the West Yorkshire STP in partnership with other acute, mental health and community providers, Clinical Commissioners and Councils across West Yorkshire to develop a Sustainability and Transformation Plan.

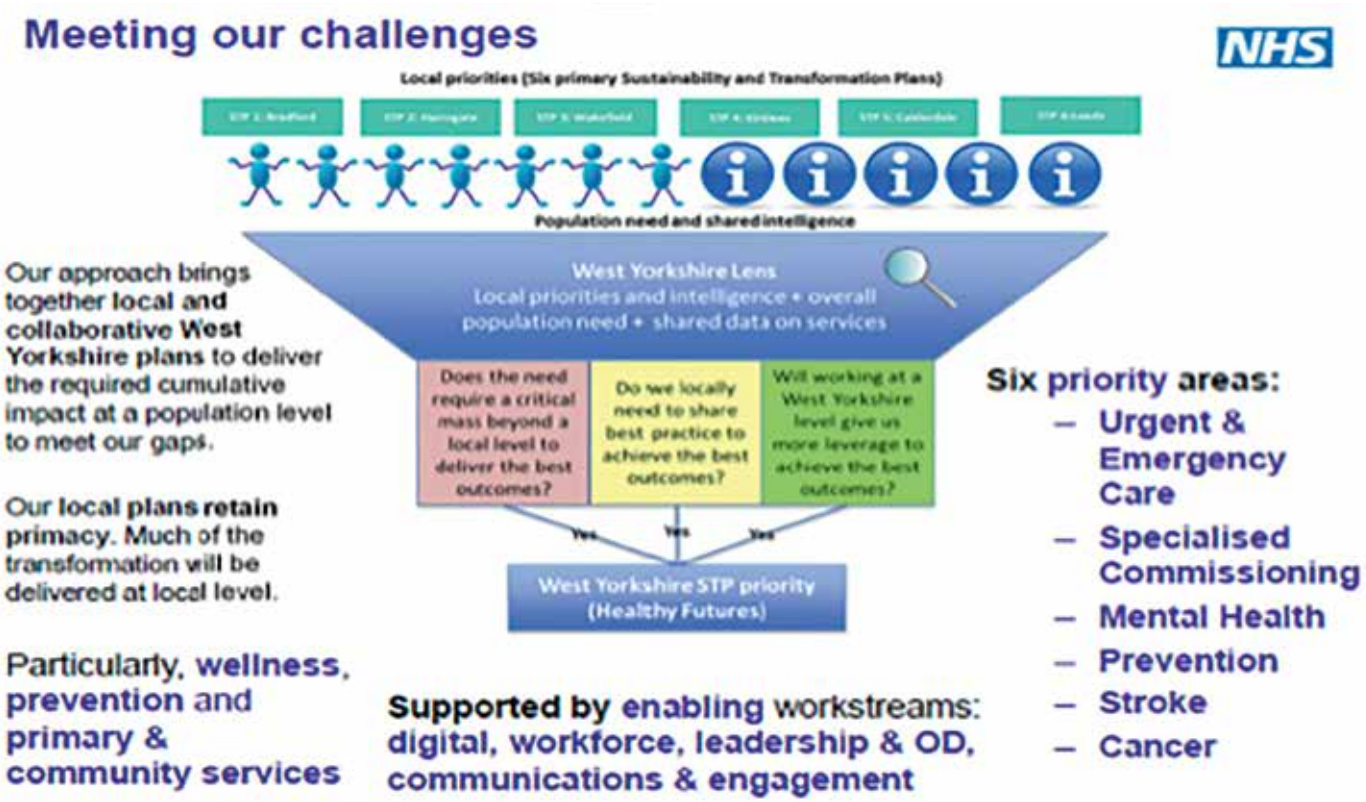


The aim of the WYSTP is to provide an agreed foundation from which the West Yorkshire system can effectively plan and prioritise health and social care transformation required over five years that will enable the West Yorkshire health and social care system to sustainability address the three key challenges ('gaps') related to health and wellbeing; care and quality, and; funding and efficiency.

The STP was submitted to NHS England in October 2016 and was published on 10 November 2016.

The vision for the West Yorkshire STP that has been developed focuses on:

- Every place will be a healthy place, with a focus on prevention and health inequalities
- Work with local communities to build community assets and resilience for health
- People will be supported to self-care as a standard offer, with technology a key to supporting people in their communities
- Care will be person centred, simpler and easier to navigate
- There will be joined-up community place-based services across mental and physical health and social care including close working with voluntary and community sector
- Local services will merge into accountable care systems to help keep people well
- Acute needs will be met through services that are "safe sized" with an acute centre in every major urban area, connected to a smaller number of centres of excellence providing specialist care
- Actively engage people in planning, design and delivery of care
- Move to a single commissioning arrangement between CCGs and local authorities
- Share back office functions, where possible, to drive efficiencies to enable investment in services



West Yorkshire Association of Acute Trusts (WYAAT)

Aligned with the work to develop the WYSTP, during 2016/17 CHFT has specifically collaborated with the other six acute hospital trusts across West Yorkshire and Harrogate to establish the West Yorkshire Association of Acute Trusts (WYAAT). This includes membership of Calderdale and Huddersfield NHS Foundation Trust, Leeds Teaching Hospitals NHS Foundation Trust, Bradford Teaching Hospital NHS Foundation Trust, Mid-Yorkshire Hospitals, Airedale NHS Foundation Trust and Harrogate NHS Foundation Trust.

New governance arrangements ('Committee in Common') have been agreed that will enable the acute hospital organisations across West Yorkshire to work more closely together and make decisions collectively. A Memorandum of Understanding has been agreed that describes the formal delegation of decisions relating to the WYAAT Collaborative Programme.

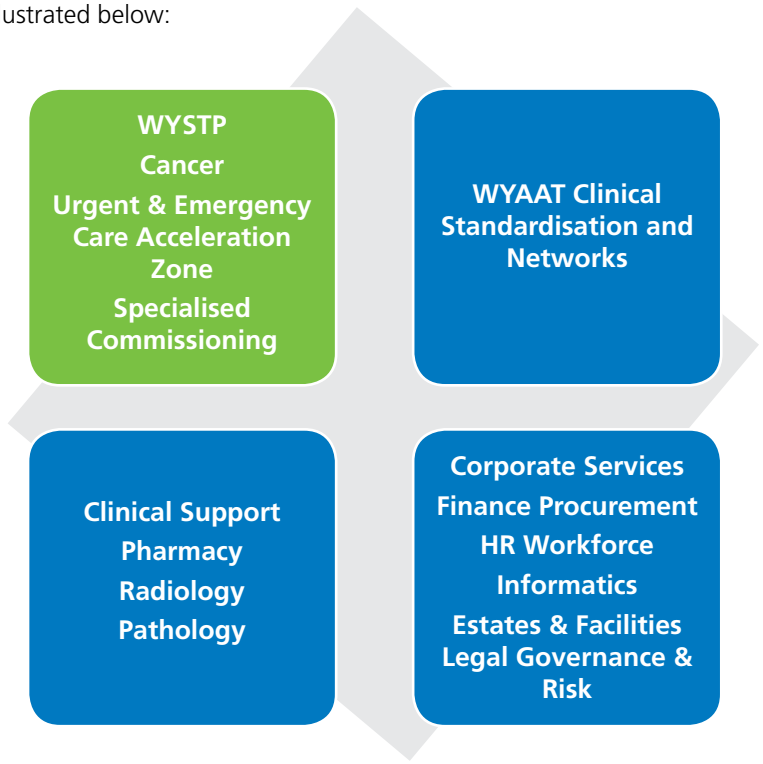
The agreed principles and five key steps to developing the WYAAT Collaborative Programme approach are set out below:

1. **Developing a 'Centres of Excellence'** approach to higher acuity specialties e.g. hyper-acute stroke, neurology, cancer, vascular, ENT, max fax, eliminating avoidable cost of duplication and driving standardisation.
2. **Developing West Yorkshire and Harrogate standardised operating procedures and pathways** across services, building on current best practice and using "Getting it Right First Time" (GIRFT) to drive out variations in quality as well as operational efficiency and facilitating safer free movement of bank staff across providers.
3. **Collaborating to develop clinical networks and creating alliances** as a vehicle (e.g. hyper acute stroke, cancer etc.) which will protect local access for patients whilst consolidating skills (and therefore resilience) and reducing operational cost of duplicated facilities. Using GIRFT, outcome variation data and WYAAT work on sustainable services to identify the case for change for specific services, the model being based on the 'chain' concept.
4. **Developing workforce planning at scale** to secure the pipeline of fit for purpose staff and improved productivity, managing workforce risk at system level, and supporting free movement of bank and agency staff under single shared Bank arrangements with the aim of reducing spend on agency and reduce the administration costs of the flexible workforce.
5. **Delivering economies of scale in back office and support functions** e.g. procurement, pathology services, Estates & Facilities Management, and other infrastructure e.g. IT. the default position being consolidation.

A programme of development work has been agreed that includes:

- Contribution to STP led workstreams where WYAAT is a significant stakeholder
- WYAAT corporate service projects (initial priorities are procurement, IM&T and Estates and Facilities)
- WYAAT clinical Support services (imaging, pharmacy and pathology)
- WYAAT clinical services (neurology, maxillo facial surgery and elective surgery)

This is illustrated below:



Right Care, Right Time, Right Place

The Right Care, Right Time, Right Place formal public consultation on the proposals for the future re-configuration of CHFT hospital services in Calderdale and Huddersfield concluded in June 2016.

On the 20th October 2016 the Greater Huddersfield and Calderdale CCGs made the decision to progress the proposed changes to Full Business Case (FBC). CHFT is currently undertaking work to develop the Full Business Case by the end of June 2017. The Calderdale and Kirklees Council Joint Health & Social Care Committee (JHSC) have considered the CCGs response to their recommendations following public consultation and confirmed that the Joint Committee will make a decision in July 2017 of whether to make a referral to the Secretary of State to review these proposals.

Remuneration Report

I am pleased to present the Remuneration Report for 2016/2017. At Calderdale and Huddersfield NHS Foundation Trust we recognise that our remuneration policy is important to ensure that we can attract and retain skilled and experienced leaders who are able to deliver our ambitious plans for delivering compassionate care. At the same time it is important to recognise the broader economic environment and the need to ensure we deliver value for money.

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

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

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

Details of the membership of the Nomination and Remuneration Committee and individual attendance can be found on P36 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 Trust's Nominations and Remuneration Committees take into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. The Committees also receive professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.' The way in which the Committees operate is subject to audit scrutiny. The work of the Committees is subject to an independent level of scrutiny by the Audit and Risk Committee and this scrutiny can be exercised at any time. The scrutiny role is set out in the Terms of Reference of the Audit and Risk Committee and the Committee Chair does not sit on the Remuneration part of the Nomination and Remuneration Committee.

The Trust has well established performance management arrangements and each year I undertake an appraisal for each of the executives and I am appraised by the Chairman. We do not have a system of performance-related pay and therefore in any discussion on remuneration an individual's performance is considered alongside the performance of the executive team and the organisation as a whole.

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

Salary and pension contributions of all executive and non-executive directors

Information on the salary and pensions contributions of all executive and non-executive directors 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 7 to 8 of the accounts.

Owen Williams
Chief Executive
23 May 2017

Salary, Expenses and Pension entitlements of senior managers

A) Remuneration

It is the view of the Board of Directors that the authority and responsibility for directing and controlling the major activities of the trust is retained by the board of directors and is not exercised below this level.

	2016-17					
Name and Title	Salary (bands of £5,000) £000	Taxable Benefits (bands of £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long Term Performance Related Bonus (bands of £5,000) £000	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
A Haigh ~ Chair	50 - 55	0	0	0	0	50 - 55
D Anderson ~ Senior Independent Non Executive Director	10 - 15	0	0	0	0	10 - 15
J Wilson ~ Vice Chair	10 - 15	0	0	0	0	10 - 15
L Patterson ~ Chair of Quality Committee (Note A)	5 - 10	0	0	0	0	5 - 10
P Oldfield ~ Chair of Finance & Performance Committee	10 - 15	0	0	0	0	10 - 15
Prof P Roberts ~ Chair of Audit & Risk Committee	15 - 20	0	0	0	0	15 - 20
R Hopkin	10 - 15	0	0	0	0	10 - 15
K Heaton ~ Chair of Workforce (Well Led) Committee	10 - 15	0	0	0	0	10 - 15
K Griffiths ~ Director of Finance (Note B)	85-90	0	0	0	15 - 17.5	100 - 105
G Boothby ~ Director of Finance (Note C)	50-55	0	0	0	25 - 27.5	75 - 80
L Hill ~ Director of Planning and Estates & Facilities	130-135	0	0	0	30 - 32.5	165 -170
J Hull ~ Director of Workforce and Organisational Development (Note D)	115-120	0	0	0	0 - 2.5	115 - 120
I Warren ~ Director of Workforce and Organisational Development (Note E)	80-85	0	0	0	25 - 27.5	105 - 110
D Birkenhead ~ Medical Director	225-230	0	0	0	30 -32.5	260 - 265
J Dawes ~ Director of Nursing (Note F)	10-15	0	0	0	0 - 2.5	10 -15
B Brown ~ Deputy Chief Executive/ Director of Nursing (Note G)	110-115	0	0	0	15 - 17.5	125 -130
H Barker ~ Chief Operating Officer	135-140	0	0	0	132.5 - 135	270 - 275
O Williams ~ Chief Executive	185-190	0	0	0	42.5 - 45	230 -235
Additional disclosure						
Band of the highest paid Director's total remuneration	225 - 230					
Median Total (£'000)	27,043					
Remuneration ratio	8					

	2015-16					
Name and Title	Salary (bands of £5,000) £000	Taxable Benefits (bands of £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long Term Performance Related Bonus (bands of £5,000) £000	Pension Related Benefits (bands of £2,500) £000	Total (bands of £5,000) £000
A Haigh ~ Chair	45 - 50	0	0	0	0	45 - 50
D Anderson ~ Senior Independent Non Executive Director	10 - 15	0	0	0	0	10 - 15
J Pease ~ Chair Quality Committee (Note A)	15 - 20	0	0	0	0	15 - 20
J Wilson ~ Vice Chair & Chair of Well Led Workforce Committee	10 - 15	0	0	0	0	10 - 15
L Patterson (Note B)	5 - 10	0	0	0	0	5 - 10
P Oldfield ~ Chair Finance & Performance Committee	15 - 20	0	0	0	0	15 - 20
Prof P Roberts ~ Chair Audit & Risk Committee	15 - 20	0	0	0	0	15 - 20
R Hopkin (Note F)	0 - 5	0	0	0	0	0 - 5
K Heaton (Note F)	0 - 5	0	0	0	0	0 - 5
K Griffiths ~ Director of Finance	145 - 150	0	0	0	5.0 - 7.5	155 - 160
L Hill ~ Director of Planning, Performance and Estates & Facilities	130 - 135	0	0	0	17.5 - 20	150 - 155
J Hull ~ Director of Workforce and Organisational Development	125 - 130	0	0	0	10 - 12.5	135 - 140
D Birkenhead ~ Medical Director	225 - 230	0	0	0	25 - 27.5	250 - 255
J Dawes ~ Director of Nursing	145 - 150	0	0	0	117.5 - 120	265 - 270
H Barker ~ Chief Operating Officer (Note E)	30 - 35	0	0	0	2.5 - 5.0	35-40
O Williams ~ Chief Executive	185 - 190	0	0	0	25 - 27.5	215 - 220
Additional disclosure						
Band of the highest paid Director	225 - 230					
Median Total (£'000)	25,229					
Remuneration ratio	9					

Non-Executive Directors do not receive pensionable remuneration; there will be no entries in respect of pension related benefits for Non-Executive Directors.
A, L Patterson on sabbatical from 01.01.16 - 01.09.16
B K Griffiths left 28.10.2016
C, G Boothby appointed 01.11.16
D, J Hull left 31.07.16
E, I Warren appointed 01.08.16
F, J Dawes left 30.04.16
G, B Brown appointed to Director of Nursing 13.06.16, appointed to Deputy Chief Executive 06.02.17

H,J Pease left 31.03.16
I, R Hopkins and K Heaton appointed 01.03.16
J, H Barker appointed 01.01.16

Additional disclosure

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

The banded remuneration of the highest-paid director in Calderdale and Huddersfield NHS Foundation Trust in the financial year 2016/17 was £228k (2015/16 was £228k). This was 8 times (2015/16, 9) the median remuneration of the workforce, which was, £27,043 (2015/16, £25,229).

In 2016/17, 3 (2015/16, 2) employees received remuneration in excess of the highest paid director. In 16/17 remuneration ranged from £232k to £254k (2015/16 £230k to £267k)

*The 15/16 numbers have been restated due to an error identified due an extrapolation of numbers, 15/16 did read 4 people were paid more than the highest paid director with a salary range of £230 -£267k. The correct numbers are 2 people with a salary range of £232k to £254k.

The salary for the Medical Director is their total remuneration package, of which £70k relates to their clinical role.

The Trust has two senior managers who are paid more than £142,500 per annum. The Trust's remuneration policy applies to Executive Directors and senior below Board level posts and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people. When setting levels of remuneration, the Trust's Nominations and Remuneration Committee also take into account the remuneration policies and practices applicable to our other employees, along with any guidance received from the sector regulator and the Department of Health. The Committee also receive professional independent reports based on objective evidence of pay benchmarking across a range of industry comparators. The conclusion reached in professional independent reports is that 'weightings accredited to the various posts in relation to market comparisons had resulted in remuneration that is in line with current pay practice.' The way in which the Committee operates is subject to audit scrutiny. The work of the Committees is subject to an independent level of scrutiny by the Audit and Risk Committee and this scrutiny can be exercised at any time. The scrutiny role is set out in the Terms of Reference of the Audit and Risk Committee and the Committee Chair does not sit on the Nominations and Remuneration Committee.

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 2017 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2016	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2017
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
K Griffiths ~ Director of Finance (Note B)	0 - 2.5	2.5 - 5.0	55 - 60	170 - 175	1,003	40	1,072
G Boothby ~ Director of Finance (Note C)	0 - 2.5	2.5 - 5.0	35 - 40	60 - 65	392	27	459
L Hill ~ Director of Planning, Performance and Estates & Facilities	0 - 2.5	5.0 - 7.5	45 - 50	145 -150	865	66	932
J Hull ~ Director of Workforce and Organisational Development (Note D)	0 - 2.5	0 - 2.5	50 - 55	155 - 160	990		
I Warren ~ Director of Workforce and Organisational Development (Note E)	0 - 2.5	0 - 2.5	15 - 20	0 - 2.5	161	24	198
D Birkenhead ~ Medical Director	2.5 - 5.0	5.0 - 7.5	70 - 75	215 -220	1,272	123	1,396
J Dawes ~ Director of Nursing (Note F)	0 - 2.5	0 - 2.5	60 - 65	180 - 185	1,159	5	1,222
B Brown ~ Director of Nursing (Note G)	0 - 2.5	0 - 2.5	0 - 5	0 - 2.5	14	16	34
H Barker ~ Chief Operating Officer	5.0 - 7.5	12.5-15	55 - 60	150-155	813	130	943
O Williams ~ Chief Executive	2.5 - 5.0	0 - 2.5	70 - 75	0 - 2.5	730	56	786

Cash Equivalent Transfer Values

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

.Real Increase/ (Decrease) in CETV

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

Staff Report

We employ 5955 colleagues across our two hospitals and in the community in Calderdale.

Gender

Directors	33% Female	67% Male	(5 Female, 10 Male – this includes Non-Executive Directors)
Senior Managers	63% Female	37% Male	(79 Female, 46 Male)
All other employees	82% Female	18% Male	(4894 Female, 1061 Male)

Staff costs

	Group			
			2016/17	2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	157,511	23,231	**180,742**	175,496
Social security costs	14,463	2,131	**16,594**	12,497
Employer's contributions to NHS pensions	19,251	2,836	**22,087**	21,336
Pension cost - other	-	-	**-**	-
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	23,439	**23,439**	19,861
Total gross staff costs	**191,225**	**51,637**	**242,862**	**229,190**
Recoveries in respect of seconded staff	**-**	**-**	**-**	**-**
Total staff costs	**191,225**	**51,637**	**242,862**	**229,190**
Of which				
Costs capitalised as part of assets	1,858	96	**1,954**	1,953

Average number of employees (WTE basis)

	Permanent		Other		2016/17 Total		2015/16 Total
	Number		Number		Number		Number
Medical and dental	267		251		**518**		513
Ambulance staff	-		-		**-**		-
Administration and estates	1,099		96		**1,195**		1,140
Healthcare assistants and other support staff	1,100		65		**1,165**		1,056
Nursing, midwifery and health visiting staff	1,645		30		**1,675**		1,662
Nursing, midwifery and health visiting learners	-		-		**-**		-
Scientific, therapeutic and technical staff	500		20		**520**		633
Healthcare science staff	113		2		**115**		-
Social care staff	-		-		**-**		-
Agency and contract staff	-		218		**218**		200
Bank staff	-		113		**113**		166
Other	-		-		**-**		-
Total average numbers	**4,724**		**795**		**5,519**		**5,370**
Of which:							
Number of employees (WTE) engaged on capital projects	45		-		**45**		23

Reporting of compensation schemes - exit packages 2016/17

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

Reporting of compensation schemes - exit packages 2015/16

	Number of compulsory redundancies		Number of other departures agreed		Total number of exit packages
	Number		Number		Number
Exit package cost band (including any special payment element)					
<£10,000	-		5		**5**
£10,001 - £25,000	-		10		**10**
£25,001 - 50,000	-		14		**14**
£50,001 - £100,000	-		4		**4**
£100,001 - £150,000	-		1		**4**
£150,001 - £200,000	-		-		**-**
>£200,000	-		-		**-**
Total number of exit packages by type	**-**		**34**		**34**
Total resource cost (£)	£0		£1,101,000		**£1,101,000**

Exit packages: other (non-compulsory) departure payments

	2016/17				2015/16		
	Payments agreed		Total value of agreements		Payments agreed		Total value of agreements
	Number		£000		Number		£000
Voluntary redundancies including early retirement contractual costs	-		-		-		-
Mutually agreed resignations (MARS) contractual costs	-		-		34		1,101
Early retirements in the efficiency of the service contractual costs	-		-		-		-
Contractual payments in lieu of notice	-		-		-		-
Exit payments following Employment Tribunals or court orders	-		-		-		-
Non-contractual payments requiring HMT approval	-		-		-		-
Total	**-**		**-**		**34**		**1,101**
Of which:							
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-		-		-		-

As part of the staff report, we are required to present the following for our highly paid and / or senior pay-roll engagements:
For all off-payroll engagements as of 31 Mar 2017, for more than £220 per day and that last for longer than six months

	2016/17
	Number of engagements
Number of existing engagements as of 31 Mar 2017	**-**
Of which:	**-**
Number that have existed for less than one year at the time of reporting	**-**
Number that have existed for between one and two years at the time of reporting	**-**
Number that have existed for between two and three years at the time of reporting	**-**
Number that have existed for between three and four years at the time of reporting	**-**
Number that have existed for four or more years at the time of reporting	**-**

For all new off-payroll engagements, or those that reached six months in duration, between 01 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months

	2016/17
	Number of engagements
Number of new engagements, or those that reached six months in duration between 01 April 2016 and 31 March 2017	**-**
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	**-**
Number for whom assurance has been requested	**-**
Of which:	**-**
Number for whom assurance has been received	**-**
Number for whom assurance has not been received	**-**
Number that have been terminated as a result of assurance not being received	**-**

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 01 April 2016 and 31 March 2017

	2016/17
	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	**-**
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	**7**

All our payroll engagements are subject to a risk-based assessment and where considered necessary, we seek assurance as to whether the individual is paying the right amount of tax. The Trust is continuing to work with agencies to ensure contractual clauses are in place.

Consultancy spend
During 2016/17 the Trust spent £61,000 on consultancy.

A workforce fit for the future

Staff feedback

National Staff Survey 2016

Following the publication of the national NHS staff survey results in March 2017, we intend to use this feedback to build on the robust action plan already in place. Regular updates on the action plan are submitted to the Workforce (Well-Led) Committee, who will monitor progress and implementation against the action plan.

Between October and December 2016 a random sample of 1250 members of staff were asked to fill in the survey and 553 responded (45%).

The results of the staff survey in 2016 have shown that staff are able to contribute to improvements at work and we have low incidences of staff experiencing discrimination at work. There is a better than average score for staff satisfaction; satisfaction with the quality of work and care staff are able to deliver; and staff confidence and security in reporting unsafe clinical practice. Staff recommending the Trust as a place to work or receive treatment scored as below average.

In 2017 we intend to focus on initiatives to improve the quality of our appraisals and provide staff with tools and techniques to improve their health and wellbeing.

Our top five ranking scores are:

1	Percentage of staff experiencing discrimination at work in the last 12 months ***CHFT 8% - national average – 11% (Trust score in 2015 – 10%)***
2	Percentage of staff able to contribute towards improvements at work ***CHFT – 73% - national average – 70% (Trust score in 2015 – 70%)***
3	Percentage of staff experiencing physical violence from staff in last 12 months ***CHFT – 2% - national average – 2% (Trust score in 2015 – 2%)***
4	Staff satisfaction with the quality of work and care they are able to deliver ***CHFT – 4.01 – national average – 3.96 (Trust score in 2015 – 3.99)***
5	Staff confidence and security in reporting unsafe clinical practice ***CHFT – 3.69 – national average – 3.65 (Trust score in 2015 – 3.68)***

Our bottom five ranking scores are:

1	Percentage of staff reporting errors, near misses or incidents witnessed in the last month ***CHFT 88% – national average 90% (Trust score in 2015 – 95%)***
2	Organisation and management interest in and action on health and wellbeing ***CHFT - 3.46 – national average - 3.61 (Trust score in 2015 – 3.40)***
3	Percentage of staff satisfied with the opportunities for flexible working patterns ***CHFT – 46% – national average – 51% (Trust score in 2015 – 41%)***
4	Percentage of staff agreeing that their role makes a difference to patients/service users ***CHFT – 89% – national average – 90% (Trust score in 2015 – 89%)***
5	Quality of appraisals ***CHFT 3.00 – national average – 3.11 (Trust score in 2015 – 2.90)***

Our score has improved for the following:

- Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves

Investors in People (IIP)

The Trust currently holds the IIP Bronze Award, awarded in December 2015. The Trust was assessed as part of its agreement to maintain the Investors in People Standard through the 'staged assessment process' during August 2016 and overall the Trust has performed in line within expectations following the initial self-assessment diagnostic. The indicative outcome findings at this stage also support many areas where the organisation has received internal feedback through its surveys, audits, internal inspections and more recently external feedback through the CQC Inspection, all of which will inform and contribute to further internal planning and improvements. The second staged assessment will take place in 2017 with the third assessment and final report in 2018.

Colleague engagement

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

By focusing clearly on our values and behaviours, alongside the development of our workforce, we aim to improve capability and capacity for transformational change. This is underpinned by direct focus on delivering an effective appraisal to continuously improve our performance against the Investors in People Standard. The Trust recognises that improving and sustaining levels of job satisfaction, engagement and wellbeing is key to its ability to deliver transformational change; and that given the scale of that change, this presents a real challenge and as such is a top priority requiring focussed leadership and grip across the organisation.

Formal engagement takes place with staff side representatives through the Staff Management Partnership Forum which meets on a monthly basis and the Medical and Dental Pay and Conditions Committee. We have six elected staff members on our Membership Council, all of whom are active in engaging with employees of the Trust as Foundation Trust Members and ensuring that they are involved in developing the work of the Trust.

The Trust has established colleague engagement and Black and Minority Ethnic networks in 2016/2017 for the purposes of informing, testing and communicating its approach to improving the colleague experience as employees.

More generally, we engage with our workforce directly through a range of channels and mechanisms that promote engagement, communication and information share:-

- Team Brief on a monthly basis, which ensures all staff receive regular updates from the Board of Directors and Executive Board meetings as well as Divisional and Departmental updates
- CHFT Weekly, an electronic newsletter for staff sharing top news stories for the week accessible through the Trust's intranet
- Our monthly staff newsletter Trust News, accessible electronically, which provides a lively mixture of service, performance and financial information as well as items about individual, team and Trust achievements
- Our staff intranet which has been refreshed to improve its design and content
- A monthly briefing session 'Big Brief' led by the Trust Directors
- 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
- Executive Directors and senior staff visit clinical areas and departments to meet with colleagues and give them the opportunity to raise any workplace issues
- The 'Ask Owen' facility provides an opportunity for colleagues to raise issues directly with the Chief Executive with questions and answers available to all staff through the intranet
- A Workforce and OD Line Manager Bulletin is published monthly to with a focus on developing/enhancing a manager toolkit that is informative, educational and practical for colleagues dealing with day to day workforce/employee issues in the Trust.

Our workforce strategy

In 2016/2017 the Board of Directors approved a 5-year workforce strategy which draws together the approaches we require to attract, retain, support, engage and reward our people as we develop and reconfigure services to meet increasing patient demand.
The financial operational, clinical and system wide challenges confronting the Trust are faced in a difficult financial environment for health and social care. It is in this context that the Trust must embark on the journey to reshape its workforce, building 'a workforce of the right size and shape with the commitment, capability and capacity to deliver safe, efficient, high quality patient care within the available resource'. .

The strategy sets out our vision to have an engaged and healthy organisational culture supported by a sustainable and capable workforce working in an integrated and co-ordinated approach with our partners. This requires us to ensure that we lead and manage in a manner which firmly demonstrates a commitment to our values and behaviours – and that we put these into action through everything we do. Our focus is on recruitment, retention, workforce planning, agency spend, attendance management, colleague engagement and organisation development and leadership

Our expectation is that:

- Colleagues are clear about the Trust's priorities, feel valued, confident that their voice is heard; and able to take an active part in decisions which affect the Trust, its patients, carers and the community.
- Colleagues are value driven and work together in pursuit of Trust priorities; the right teams are in the right place at the right time collaborating to deliver safe, efficient, high quality patient care within the available resource.
- Colleagues are professional and capable, feel equipped to make an effective contribution to Trust priorities and are actively supported by a directive and inclusive leadership community.
- Colleagues are resilient, feel supported to improve

and maintain their health and wellbeing, sustaining their availability for work to the benefit of patients and fellow team members.
- Colleague development will be supported by focus upon the Investors in People standards and will be underpinned by delivery of an effective appraisal. We will continue to strive for improvement utilising the Investors in People Standard as a key approach for driving and analysing our delivery.

A Workforce (Well Led) Committee chaired by a Non-Executive Director and reporting to the Board of Directors has been established to secure assurance that progress in implementing the strategy is being made. A Workforce Modernisation Programme Board led by the Director of Workforce and Organisational Development will oversee the delivery of the strategy.

Colleague health and wellbeing

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

The 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 colleague wellbeing, support for staff and managers on mental health pathways and reducing the impact of musculoskeletal conditions. A five year wellbeing strategy has been co-created with feedback from colleagues, and identifying the key areas for local development. In addition, there is a CQUIN for wellbeing which frames our activity around organisational care for the wellbeing of colleagues, improved mental health awareness and training and reducing incidents of back pain. The Trust successfully delivered all its activities in 2016/2017 described in its CQUIN action plan. This included a 75% take-up of the flu vaccine by colleagues [image from the flu campaign] in the Autumn/Winter of 2016 and improvements in the provision of healthy food options in all of the Trust's on-site retail and catering facilities. 2017 also saw the planting of our first wellbeing garden at the Calderdale Royal Hospital site and the creation of a gardening staff group for staff to join and help maintain this tranquil and edible garden.

The Trust launched its wellbeing handbook co-created by colleagues and featuring guidance and signposting for many of the wellbeing opportunities for staff.

A wellbeing active mobile phone app continues to be available to all staff and their families, with helpful tips on keeping well and getting active.

The Trust supports physical activity and its annual Men's Health Football event again proved popular. This will be repeated in June 2017 with plans to develop a wider regional tournament.

The Trust is continuing to work with partner colleagues from the Calderdale health improvement team which we hope will 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.

Mental Wellbeing

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

Musculoskeletal Pain

In conjunction with colleagues in physiotherapy intranet information and self- help treatment information and training has been published on the intranet. A direct referral to physiotherapy service can be accessed by CHFT colleagues via the Occupational Health pages of the intranet.

Physical activity and wellbeing
- 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 has been established and is growing, to support local engagement and leadership on a particular health interest or in a geographical area, and to promote the health and wellbeing messages

Appraisal and development

Appraisal activity at the end of 2016/2017 showed a 96.55% compliance with the requirement to be appraised. This was an improvement in the outturn seen in 2015/2016. An appraisal season is to be introduced in 2017/2018 from July to October to focus activity to deliver at least 97% compliance and to drive improvement in the reported experience from colleagues of appraisal.

Mandatory training remains a key focus with room for improvement in 2017/2018. This training helps employees achieve safety and efficiency in a timely manner. The mandatory training programme, which largely comprises e-learning, enables the Trust to demonstrate that employees regularly have mandatory training designed to ensure they can undertake their job roles safely and maintain a safe and healthy work environment. The Trust's approach identifies what training employees are required to complete, how often they are required to complete the training and how to access the training. Compliance continues to be a focus for the Trust and it presents a challenge to compliance rates varying between 71% and 91% for the 5 subjects from the 10 elements of the programme which were not deferred in 2016/2017 due to EPR implementation.

Attendance Management

The Trust's sickness absence rate for 2016/17 was 4.36%. The absence data reported below is provided by NHS Digital for the calendar year, January to December 2016.

Days Available Full time equivalent (FTE)	Days recorded Sickness Absence (FTE)	Average annual sick days per (FTE)
1,873,428	51,470	10.0

The Trust recognises that the health and wellbeing of its employees is a key determinant of safe and high quality services. It is an essential feature of its Board approved workforce strategy. High rates of absenteeism are costly, from an economic point of view as well as the impact on the morale of the workforce and the potential loss of continuity of patient care. The Trust has a policy which supports regular attendance at work that enables managers to manage attendance fairly, with a focus on rehabilitation and return to work wherever possible. The Trust is also developing a proactive approach to colleague health and wellbeing in response to feedback received in the staff survey.

Medical Education

In 2016 we welcomed our first Physician Associate and Physician Associate students to the Trust. Whilst Physician Associates are now established roles in the NHS, the student placements were new to CHFT and the placements have proved really positive, both for the students and the Trust. The Trust is now in the process of appointing PA's who present an alternative workforce for tasks traditionally performed by junior doctors, bringing a resource of generic skills and competence that eventually will be able to work across the hospital and provide a mitigation of covering deanery gaps without the need for a temporary workforce

Once again we achieved a 100% response rate to the GMC Doctor in Training Survey. We scored the fourth highest rating out of 14 Trusts in the region (5th in 2015), the 2016 results were the best position we have ever attained). We were particularly pleased that we were rated best for overall satisfaction in all Yorkshire & Humber for Emergency Medicine, Acute Internal Medicine, Stroke Medicine, General Surgery and Vascular Surgery

Working with multi professional staff a number of our doctors in training took the lead in developing educational programmes for our medical students:

- The Prescribing at Calderdale and Huddersfield (PATCH) course looks to integrate the multi-disciplinary team approach to medicine allowing for co-operative working between doctors, nurses and pharmacists. The course was aimed at final year medical students from Leeds, final year nursing students and pharmacy students from Huddersfield University. Two hour lectures took place once a week for 3 weeks and were delivered by FY1's, pharmacists, dieticians, nursing staff and a microbiology consultant. In this way, Trust specific prescribing scenarios were outlined and discussed, hopefully enabling the students to gain confidence before starting their careers. The feedback was great and the course recently won an Association of the Study of Medical Education Award.
- A number of our doctors in training took the initiative to deliver targeted teaching on common or more difficult OSCE questions (Observed Structured Clinical Examination) for our 4th year medical students on placement. The final months before 4th year exams are stressful and the students found the situation specific teaching really helpful and a number commented on how the training helped them feel more confident about the exam ahead.
- One of our FY2 trainees, Dr Joe McFarlane recently won a Clinical Teaching Excellence and Development Award from the University of Leeds for developing a fantastic teaching programme for Leeds medical students.

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.


Pharma
Pathol
CAUTION
WET FLOOR

Disclosures set out in the NHS Foundation Trust Code of Governance

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

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

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

Comply or explain

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

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

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

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

- Standing Orders, Standing Financial Instructions, Scheme of Delegation and Constitution.
- Standards of Business Conduct and Register of Declarations of Interest
- Integrated Board report
- Board and Committee reports and the supporting minutes
- Annual business cycle of the Board of Directors and its Committees
- Risk Management Policy and Procedure
- Job description and role description of the Senior Independent Director
- Terms of reference of the committees and sub-committees of the Board of Directors and Membership Council
- The Board of Directors skills and capabilities matrix
- Non-Executive Director candidate information pack and induction programme
- Appraisal policy
- Well-led Governance Review report
- 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

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

Directors

The Trust is headed by a Board; it exercises its functions effectively, efficiently and economically. The Board is a unitary board consisting of a non-executive chair, seven non-executive directors and seven executive directors. Full details of members of the Board can be found on P32 including changes to the membership of the board during 2016/17.

The Board provides active leadership within a framework of prudent and effective controls and monitors compliance with the terms of its licence. The Board meets a minimum of 9 times a year so that it can regularly discharge its duties.

The non-executive directors hold executive directors accountable through scrutiny of performance outcomes, management of business process systems and quality controls, and satisfy themselves as to the integrity of

financial, clinical and other information. Financial and clinical quality control systems of risk management are robust and defensible.

The non-executive directors, through the Nominations and Remuneration Committee, fulfil their responsibility for determining appropriate levels of remuneration of executive directors. The Committee is provided with benchmark data to support the decision being made about the level of remuneration for the executive directors. More details about the Nominations and Remuneration Committee can be found on P36.

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

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

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

The Chair

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

Governors

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

The Membership Council consists of elected and appointed councillors. More than half are public governors elected by community members of the trust. Elections take place once every year, or on other occasions, if required due to vacancies or a change in our constitution. The next elections will be held during summer 2017.

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

Information, development and evaluation

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

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

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

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

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

Performance evaluation of the board and its committees

During the year the Board has implemented the actions resulting from the Well-led Governance Review as prescribed by NHS Improvement. The review concentrates on the quality of the governance in place in the organisation. In addition, learning from the well-led findings of the Care Quality Commission inspection has been incorporated into the action plan. Progress against the action plan was monitored through the Trust's monthly performance review meetings with NHS Improvement and was delivered and signed off as complete in November 2016. More details of the outcome of the review can be found on P36.

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

Resolution of disputes between the Council of Governors and the Board of Directors

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

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

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

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

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

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

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

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

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, membership council meetings, and attending the annual members' meeting. The directors also hold a joint workshop with the membership councillors twice a year.

Board balance, completeness and appropriateness

As at year ending 31 March 2017, the Board of Directors for Calderdale and Huddersfield NHS Foundation Trust comprised of seven Executive Directors, seven Independent Non-Executive Directors and an Independent Non-Executive Chairman.

Appraisal of board members

The Chairman has conducted a thorough review of each Non-Executive Director to assess their independence and contribution to the Board of Directors and confirmed that they are all effective independent Non-Executive Directors. A programme of appraisals has been run during 2016/17 and all Non-Executive Directors have undergone an annual appraisal as part of the review.

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

The Board of Directors maintains a register of interests as required by the constitution and Schedule 7 section 20 (1) National Health Service Act 2006 (see p34).

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

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

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

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

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

Internal audit function
The Trust has an internal audit function in place that provides support to the management of the organisation. Details of the internal audit function can be found on p36.

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

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

Corporate Directors' remuneration
The Nominations and Remuneration Committee meets on a regular basis and as a minimum once a year to review the remuneration of the corporate directors. Details of the work of the Nominations and Remuneration Committee can be found on p36. The Membership Council has a Nominations and Remuneration Committee which meets as required during the year. Part of the role of this Committee is to review the remuneration of the non-executive directors. Details of the Membership Council's Nominations and Remuneration Committee can be found on p36.

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

Relations and stakeholders
The Board of Directors has ensured that there is satisfactory dialogue with its stakeholders during the year. Examples of the Trust working with stakeholders can be found on p46.

Mandatory disclosures

Code provision	Requirement	Location in Annual Report
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Accountability Report p68
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Accountability Report p30
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Accountability Report p75
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Accountability Report p75
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	Accountability Report p75
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Accountability Report p32
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Accountability Report p32 and p68
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Accountability Report p36
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	N/A
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	No other significant commitments to report
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Accountability Report p80

Code provision	Requirement	Location in Annual Report
FT ARM	If, during the financial year, the Governors have exercised their power to require one or more of the directors to attend a meeting for the purpose of providing information about the Trust's performance of its functions or the directors' performance of their duties, then information on this must be included in the annual report.	N/A
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Accountability Report p67
B.6.2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	Performance Report p26
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Accountability Report p87 and p102
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Accountability Report p87
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Accountability Report p36
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	N/A
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: - the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; - an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and - if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Accountability Report p36

Code provision	Requirement	Location in Annual Report
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	N/A
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Accountability Report p80
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Accountability Report p77
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Accountability Report p80
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Accountability Report p81
FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	Accountability Report p34

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

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;	p60
The foundation trust's policies in relation to disabled employees and equal opportunities;	p84
Information on policies and procedures with respect to countering fraud and corruption;	p85
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998	p40
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year.	P17
The number of and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Accounts
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Accounts
A statement that the NHS foundation trust has complied with the cost allocation and charging guidance issued by HM Treasury	Accounts
Details of serious incidents involving data loss or confidentiality breach	Annual Governance Statement

Voluntary disclosures

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

Summary of disclosure	
Sustainability reporting	Performance Report p26
Equality reporting	Accountability Report p84
The NHS Constitution	Accountability Report p85

Our Membership Council

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.

The Membership Council has selected a lead Councillor who is also the Deputy Chair. The lead Councillor is Peter Middleton.

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 2016 the following elections were made with each member being offered a 3 year term with effect from 15 September 2016:-

CONSTITUENCY	NAME	RE-ELECTED/ELECTED	ELECTION TURNOUT
Constituency 2	Mrs Veronica Maher	Elected	Turnout 10.4%
Constituency 2	Mrs Katy Reiter	Elected	Turnout 10.4%
Constituency 3	Mrs Dianne Hughes	Elected unopposed	Unopposed – N/A
Constituency 4	Mrs Nasim Banu	Elected unopposed	Unopposed – N/A
Constituency 5	Mr Stephen Baines, MBE	Elected	Turnout 16.6%
Constituency 8	Mrs Michelle Rich	Elected	Turnout 17.6%
Constituency 10	Mrs Nicola Sheehan	Elected	Turnout 16.2%
Constituency 12	Mrs Linda Dawn Salmons	Elected unopposed	Unopposed – N/A
Constituency 13	Mrs Charlie Crabtree	Elected unopposed	Unopposed – N/A

Councillors and the Trust working together

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

Membership Council meetings
Membership Council meetings are held four times a year, plus the Annual General Meeting. Board directors are invited to attend and report on standing agenda items such as business planning, service developments, quality and the Trust's financial position. Non-executive directors attend as observers. The Membership Council receives the Integrated Board Report at each of its meetings presented by the Chief Operating Officer; the Director of Finance, and the Director of Nursing. The Membership Council also receives minutes and papers of the monthly board of director meetings.

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

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

Divisional Reference Group meetings
Divisional Reference Groups are chaired by a Membership Councillor and attended by the respective Divisional Director, Director of Operations and Associate Director of Nursing. These groups are an opportunity for Membership Councillors to meet with and ask questions of clinical and managerial Trust colleagues. Divisional plans and performance are discussed; along with compliments and complaints; and staffing or clinical issues.

Chair's Information Exchange
The Trust chairman is informed of the discussions and decisions of the respective divisional reference groups at the quarterly Chair's Information Exchange meeting. In turn, the chairman 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

Attendance at Membership Council meetings – 2016-17

MEETING DATES		7.4.16	6.7.16	15.9.16 AGM	9.11.16	17.1.17	TOTAL
PUBLIC – ELECTED							
1	Mrs Rosemary Claire Hedges	✔	✔	✔	✔	✔	5/5
1	Mrs Di Wharmby	✖	✔	✔	✖	✔	3/5
2	Rev Wayne Clarke	✔	✔	✔ Tenure ceased 15.9.16	-	-	3/3
2	Mrs Veronica Maher	-	-	✔ Tenure comm. 15.9.16	✔	✔	3/3
2	Mrs Katy Reiter	-	-	✔ Tenure comm. 15.9.16	✖	✖	1/3
3	Mr Peter John Middleton	✖	✔	✔	✔	✔	4/5
3	Ms Dianne Hughes	✖	✔	✔	✔	✖	3/5
4	Mrs Nasim Banu Esmail	-	-	✔ Tenure comm. 15.9.16	✔	✔	3/3
4 *	Mr Grenville Horsfall	-	-	✖ Tenure comm. 15.9.16	✖	✖	0/3
5	Mr Grenville Horsfall	✖	✔	-	-	-	1/2
5	Mr George Edward Richardson	✔	✖	✔	✔	✔	4/5
5	Stephen Baines	-	-	✖ Tenure comm. 15.9.16	✔	✔	2/3
6	Mr Brian Richardson	✔	✖	✔	✖	✖	2/5
6	Mrs Annette Bell	✔	✖	✖	✔	✖	2/5
7	Ms Kate Wileman	✔	✔	✖	✔	✖	3/5

MEETING DATES		7.4.16	6.7.16	15.9.16 AGM	9.11.16	17.1.17	TOTAL
7	Mrs Lynn Moore	✔	✔	✔	✔	✖	4/5
8	Mrs Michelle Rich	-	-	✖ Tenure comm. 15.9.16	✔	✖	1/3
8	Mrs Jennifer Beaumont	✔	✖	✔ Tenure ceased 15.9.16	-	-	2/3
8	Mr Brian Moore	✔	✔	✔	✔	✔	5/5
STAFF – ELECTED							
9 - Drs/ Dentists	Dr Mary Kiely	✖	✖	✖	✖	✖	0/5
10 - AHPs/ HCS/ Pharm's	Mrs Nicola Sheehan	-	-	✖ Tenure comm. 15.9.16	✖	✖	0/3
11 - Mgmt/ Admin/ Clerical	Mrs Eileen Hamer	✖	✔	✖	✖	✖	1/5
12 - Ancilliary	Mrs Linda Dawn Salmons	-	-	✖ Tenure comm. 15.9.16	✖	✖ Resigned 14.12.16	0/3
13 - Nurses/ Midwives	Mrs Charlie Crabtree	-	-	x Tenure comm. 15.9.16	✔	✔	2/3
13 - Nurses/ Midwives+	Mrs Chris Bentley	✔	✔	✖ Tenure ceased 15.9.16	-	-	2/3
NOMINATED STAKEHOLDER							
University of Huddersfield	Dr Cath O'Halloran	✔	✔	✖	✔	✔	4/5
Calderdale Metropolitan Council	Cllr Bob Metcalfe	✔	✔	✔	✔	✖	4/5
Kirklees Metropolitan Council	Cllr Naheed Mather	✖	✖ Tenure ceased 11.7.16	-	-	-	0/2
Kirklees Metropolitan Council	Cllr Carole Pattison	-	-	- Tenure commenced 22.9.16	✖	✖ Resigned 5.1.17	0/2
Clinical Commissioning Group	Mr David Longstaff	✖	✖	✖	✖	✖	0/5
Locala	Mrs Sharon Lowrie	✖	✖	✖	✖	✖	0/5
South West Yorkshire Partnership NHS FT	Mrs Dawn Stephenson	✔	✖	✖	✖	✖	1/5

* Reserve Register from 15.9.16
\+ Reserve Register from 18.9.15 – 15.9.16

Councillor training and development

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

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
There are seven two-hour sessions which provide the opportunity for Membership Councillors to learn about the systems and processes of the NHS and of the Trust. In turn, these support our Membership Councillors to feel more confident in their duty to hold non-executive directors to account for the performance of the board. These interactive and informative sessions cover such topics as 'Understanding Quality in the NHS', 'An Introduction to NHS Finance', 'Improving the Patient Experience' and 'Holding to Account'.

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

Understanding Membership Councillors' views

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

Chairman's One-to-One meetings
The Trust chairman meets quarterly with the deputy chairman of the Membership Council for an exchange of views and an update on current topics. In addition, 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.

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

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

Expenses claimed by Councillors during 2016/17

Membership Councillors do not receive payment for their work with the Trust, however we do have a policy for re-imbursement of any necessary expenditure while on Trust business at a rate of 0.28p per mile. During 2016/17 the following expenses were claimed:

	2015/16	2016/17
Total number of Councillors	26	15
Total number of claiming expenses	8	8
Total amount of expenses claimed	£643.30	£708.91

Related party transactions

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

There were no such transactions for the period 1 April 2016 to 31 March 2017.

Register of Membership Councillors' interests

All Membership Councillors have a responsibility to declare relevant interests as declare relevant interests as defined in our Constitution. These declarations are made to the Board Secretary and are reported to the Council and entered into a register. The public can access the register at www.cht.nhs.uk or by making a request in writing to:
The Board Secretary
Calderdale and Huddersfield NHS Foundation Trust
Acre Street
Lindley
Huddersfield
HD3 3EA

Membership of the committees and groups

The Membership Council has established a Nominations and Remuneration Committee to consider the pay and succession arrangements for the non-executive directors.

Nominations and Remuneration of Non-Executive Directors

The Nominations and Remunerations Committee (Membership Council) met on three occasions during 2016/17 and:

- Reviewed and agreed that their terms of reference should remain unchanged.
- In line with the pay decisions for the Board Directors in 2016-17, the proposal for the Non- Executive Directors to maintain their current levels of basic remuneration and receive no uplift was agreed.
- Agreed the extension of Dr Linda Patterson and Phil Oldfield for a further 3 year tenure. Agreed the extension of the Chairman and Dr David Anderson for a further one year tenure, along with the recruitment process to the remaining two Non-Executive positions whose tenures are due to complete later in the summer of 2017.

The Sub Committee for the Nominations and Remuneration Committee (Membership Council) during 2016/17 comprised of:-

ATTENDANCE			
NAME AND ROLE	21.7.16	18.10.16	8.3.17
Mr Andrew Haigh, Chairman	✔	✔	✔
Rev Wayne Clarke, Publicly Elected Member (Deputy Chair until Sept 2016)	✖	-	-
Mrs Eileen Hamer, Staff Elected Member	✖	✔	✔
Mr Peter Middleton, Publicly Elected Member (Deputy Chair from Sept 2016)	✔	✔	✔
Mr Brian Moore, Publicly Elected Member	✔	✔	✔
Mr Brian Richardson Publicly Elected Member	✖	✖	✖
Mrs Dawn Stephenson, Nominated Stakeholder	✔	✔	✖
Mrs Di Wharmby, Publicly Elected Member	✔	✔	✔

Our Membership

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

Our members have the chance to:

- Find out more about the hospitals, our community services, the way they are run and the challenges they face
- Help us work with local people to improve the care and experience of patients and their carers
- Elect representatives to the 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 31 March 2017		
Group	Constituency	Number
Public	1	546
	2	1710
	3	1060
	4	457
	5	1078
	6	647
	7	1244
	8	1817

Our membership as at 31 March 2017		
Staff	9 Doctors/dentists	450
	10 AHPs/NCS/ Pharmacists	746
	11 Mgmnt/Admin/ Clerical	1178
	12 Ancillary	1782
	13 Nurses/midwives	1927

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

Membership Strategy and Getting Involved

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

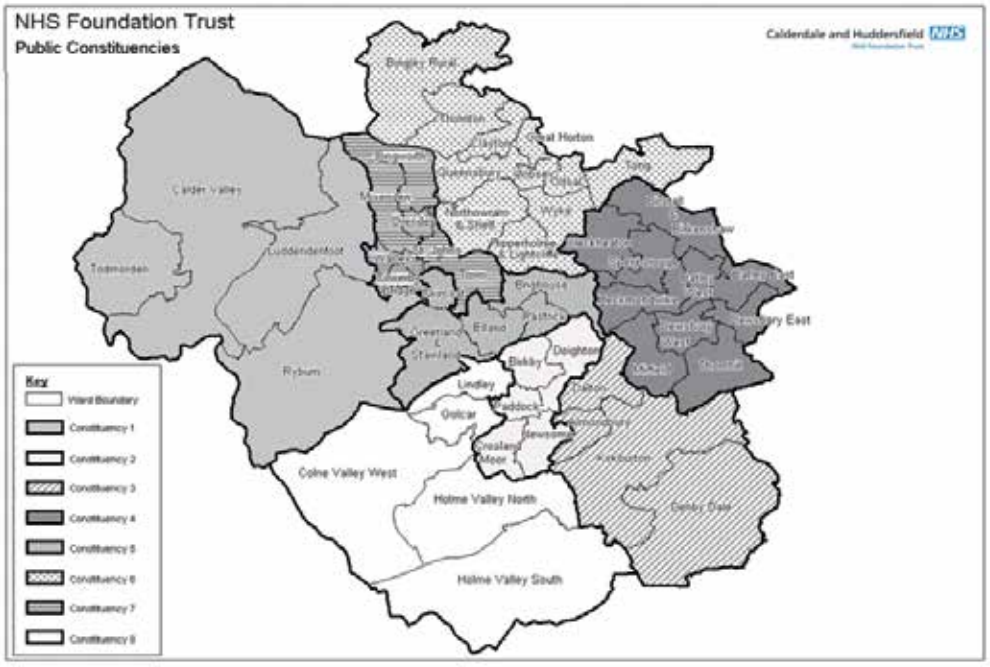
- The views of members and Membership Councillors are an important element in the recruitment process for senior Trust clinical staff. Membership Councillors and members have been part of the patient and user panels for the appointment of new consultants, senior nurses and senior non-clinical staff
- Members and Membership Councillors have taken part in the PLACE (Patient Led Assessment of the Care Environment) inspections
- Members and Membership Councillors have taken part in patient food tasting exercises
- Familiarisation tours or 'walkabouts' are conducted by Membership Councillors to help their understanding of the Trust's services for patients. Membership Councillors talk to both patients and staff to form a view about culture and performance. Areas covered this year include 'Meet the Teams' tour of the Community division; Theatres, the Day Surgery Unit and our Intensive Therapies Unit at HRI, the Trust's simulation training suite at HRI
- Membership Councillors discussed and submitted a separate document to the formal public consultation on the local 'Right Care, Right Time, Right Place' proposals. This was in order to represent the views of members, and of members of the public in this important health and social care initiative.
- Choosing quality indicators for our Quality Accounts. Membership Councillors discuss the indicators and are invited to give their views on these or to add their own suggestions. Members and Membership Councillors then vote on the suggested improvement indicators, and progress against them is published in the Trust's Quality Accounts.
- 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
- Members were invited to give feedback on the Trust's End of Life Care strategy
- One Membership Councillor helped with an observation of an interaction between a patient and a healthcare professional (as part of a staff member's studies for a master's degree in NHS leadership)
- Membership Councillors gave feedback on the content and format of a patient survey about services from the Trust's Estates and Facilities division
- One Membership Councillor conducted interviews with patients to help Trust colleagues understand women's experience of maternity care.
- Members can pose questions directly to the chief executive or Trust chairman through a 'Members' Questions Inbox'. Similarly, members can contact the Membership Councillors via the Trust's dedicated 'Contact Your Council Inbox'.

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

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

Regulatory report

Explanation of ratings

All NHS foundation trusts require a licence from Monitor (now NHS Improvement) stipulating the specific conditions they must meet to operate, including financial sustainability and governance requirements. The Risk Assessment Framework was the document used by Monitor to assess each NHS foundation trust's compliance with two specific aspects of its provider licence: the continuity of services and governance licence conditions.

The Risk Assessment Framework looked at:

- significant risk to the financial sustainability of a provider of key NHS services that endangers the continuity of those services and/or
- poor governance at an NHS foundation trust, including poor financial governance and inefficiency.
-

As part of this NHS foundation trusts were assigned a financial sustainability risk rating (CoSRR) calculated using a capital service metric, liquidity metric, income and expenditure (I&E) margin metric and variance from plan metric.

The governance rating was determined using information from a range of sources including national outcome and access measures, outcomes of Care Quality Commission (CQC) inspections and aspects related to financial governance and delivering value for money.

Our risk rating for the first two quarters of 2016/17 is shown in the table below:

2016/17	Annual Plan	Q1	Q2
Financial risk rating/Use of Resources	2	2	2
Governance rating	Red	Red	Red

Our performance for 2015/16 is provided below for comparison:

2015/16	Annual Plan	Q1	Q2	Q3	Q4
Financial risk rating	2	2	2	2	2
Governance rating	Red	Red	Red	Red	Red

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

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

The SOF assesses providers' performance against five themes:

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

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

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

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

Finance and use of resources metrics

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

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

These metrics are similar to the ones previously used to calculate the Trust's CoSRR, with the addition of the agency spend metric. Providers score 1(best) to 4 against each metric and the score is averaged across all the metrics to derive a use of resources score.

The Trust's performance against the Single Oversight Framework for quarters 3 & 4 for 2016/17 were:

2016/17	Annual Plan	Q3	Q4
Financial risk rating/Use of Resources	3	3	3

Operational performance metrics

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

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

The operational performance metrics are monitored monthly by the Board through the Integrated Performance Report. More information on the Trust's performance against these standards and further disclosures in relation to income and the Going Concern statement can be found in the Performance Report on p20.

Voluntary disclosures

Equality & Diversity

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

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

In line with the Trust's "Putting the Patient First" strategy for patient and public involvement and Equality and Diversity, and in order to strengthen engagement with users and other members of our local communities, for the first time in 2016, the Trust appointed Engagement Champions from across all its divisions.

The Engagement Champions' role is to act as the conduit between the Equality and Diversity function and the divisions. The Director of Nursing/Deputy Chief Executive is the nominated executive lead for the Engagement Champions project, and has pledged his support to the Engagement Champions in undertaking their role.

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

We have identified our priority outcomes for 2016 to 2020 as:

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

Some examples of actions we are already taking to achieve these outcomes are:

Protected Characteristic	Actions
All	We have reviewed our process for carrying out equality impact assessments and launched a new electronic process which includes a mechanism to ensure that assessments are always carried out before new policies or service changes are introduced.
Age	The Trust is purchasing "dementia friendly" crockery for wards that typically care for dementia patients at HRI. The crockery is considered to be the best product available for this group of patients.
Age	Any child under the age of 12 having their blood taken now attends the Children's Outpatient Department rather than the main Phlebotomy Department, making it a less traumatic experience for them.

Protected Characteristic	Actions
Age/Disability (visual impairment)	Bedside table child-friendly sheets are now available in yellow print for children with a visual impairment.
Disability (hearing impairment)	Following consultation with our local deaf community, we changed our service provider for BSL to a small, local company that has worked with us to design our own BSL booking website and only provides BSL services, thus ensuring a high quality service for our deaf patients. A 6-month review of the service was carried out in 2016, which showed that the service provided is of high quality and patient experience has improved.
Disability (mental health)	In the Community division, to reduce the incidence of post-natal depression in new mums, a "buggy walk" initiative has been introduced to bring mums together in groups and reduce feelings of isolation.
Religion/belief	A "Faith Card" has been produced by our Coordinating Chaplain and the steering group working on building bridges with the Muslim community, to raise colleagues' awareness of the needs of patients from different faiths. The Faith Card is to be distributed to all clinical areas.

The Trust published its annual Workforce Race Equality Standard (WRES) in 2016. The WRES is a national equality standard for employment against which all NHS organisations are assessed. The standard has nine indicators and has been developed to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for BME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The Trust's WRES has identified a number of areas where improvement is required and these relate to recruitment, career progression and bullying and harassment.
In January 2016, the Trust's Chief Executive invited BME colleagues to attend a focus group. A total of 7 focus groups were held between January and March 2016 and 47 colleagues from across all staff groups attended.

Focus group participants were asked to comment on what their experience was of working in the Trust, how they would like things to be in the future and what the Trust needed to do to improve. Feedback from each focus group was collated and consistent themes used to formulate an action plan. An executive lead is responsible for each action and works with BME colleagues who volunteered to work on the actions in task and finish groups. One of the actions was to create a BME Network. This was established and had its first meeting in September 2016.

Slavery and Human Trafficking Act 2015

The board of directors approved a statement at its meeting in March 2016 confirming compliance with the requirements of the Slavery and Human Trafficking Act 2015. The required statement has been published on the trust's website and can be found at www.cht.nhs.uk/publications.

Counter-fraud policies and procedure

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

The NHS Constitution

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

Owen Williams
Chief Executive
23 May 2017

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 (now NHS Improvement).

Under the NHS Act 2006, NHS Improvement 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 NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* 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: 23 May 2017

Annual Governance Statement 2016/17

Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

There are arrangements in place for sharing views and working with other organisations. Those operating at Chief Executive level are as follows:

- West Yorkshire Association of Acute Trusts
- West Yorkshire Sustainability and Transformation Partnership
- NHS Calderdale Clinical Commissioning Group
- NHS Greater Huddersfield Clinical Commissioning Group
- Health Overview and Scrutiny Committees (Calderdale, Kirklees)
- Health and Wellbeing Boards (Calderdale, Kirklees)
- Healthwatch (Calderdale, Kirklees)
- Calderdale and Greater Huddersfield Transformation Board
- Yorkshire and Humber Learning Education and Training Board

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;
- 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 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust's vision is 'Together we will deliver outstanding compassionate care to the communities we serve'. This is supported by the Trust's values, the four pillars of behaviour that it expects all employees to follow. These are:

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

The Trust's governance arrangements support these behaviours.
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
- Workforce Well-Led 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 are being actively managed. 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 Chief Executive has overall responsibility for the management of risk. Other members of the Director Team exercise lead responsibility for the specific types of risk as follows:

- Strategic risk: Chief Executive
- Clinical and quality risks: Director of Nursing / Medical Director
- Financial risk: Director of Finance
- Workforce and staffing risk: Director of Workforce and Organisational Development
- Environmental risk: Director of Planning, Estates and Facilities
- Operational risk: Chief Operating Officer
- IT risk Director of Health Informatics

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

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

These responsibilities are supported operationally by divisional directors and managers.

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

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

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

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

Risk Category	This means	Risk Appetite level	Risk Appetite
Strategic / Organisational	We are eager to be innovative and choose options offering potentially higher rewards to deliver high quality patient care (despite greater inherent risk).	**SEEK**	**SIGNIFICANT**
Reputation	We will maintain high standards of conduct, ethics and professionalism, with an appetite to take decisions with potential to expose the organisation to additional scrutiny / interest.	**OPEN**	**HIGH**
Financial / Assets	We will strive to deliver our services within our financial plans and adopt a flexible approach to financial risk. We are prepared to invest in resources that deliver improvements in quality and patient safety, which will be subject to rigorous quality impact assessments. Value and benefits will be considered, not just price. We will aim to allocate resources to capitalise on opportunities.	**OPEN**	**HIGH**
Regulation	We have a limited tolerance for risks relating to compliance and regulation. We will make every effort to meet regulator expectations and comply with laws, regulations and standards that those regulators have set, unless there is strong evidence or argument to challenge them and we would want to be reasonably sure we would win any challenge.	**CAUTIOUS**	**MODERATE**
Innovation / Technology	The risk appetite for innovation / technology is significant as we view these as key enablers of operational delivery. Innovation is pursued which challenges current working practices to support quality, patient safety and effectiveness, operational effectiveness and efficiency.	**SEEK**	**SIGNIFICANT**

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

In addition there is training in incident investigation, including documentation, root cause analysis, serious incidents and steps to prevent or minimise recurrence and reporting requirements. Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons learned and to help improve internal control and are reported to the Board through the quarterly Quality Report.

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

The risk and control framework

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

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

Over the last 12 months the Trust has undertaken a comprehensive review of its risk management arrangements to ensure that they are robust. This has included the development of a Risk Management Strategy and a revised Risk Management Policy. In addition the Board has discussed its risk appetite and approved a risk appetite statement to be reviewed annually.

Risk Management Objectives

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

- Risks which may adversely affect patients, staff, contractors, the public and the fabric of buildings, are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach thereby providing a safe environment in which patients can be cared for, staff can work and the public can visit.
- Risks are managed to an acceptable level as defined in the Board's Trust risk appetite and staff have a clear understanding of exposure and the action being taken to manage significant risks.
- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated.
- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively – see section 9 for further details.
- All staff recognise their personal contribution to risk management
- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

Risk Management Policy and reporting

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 evaluates the severity and likelihood of each risk and determines the priority based on the overall level of risk exposure.

iv. Risk Response
There are a number of different options for responding to a risk. These options are referred to as risk treatment strategies. For each risk, controls are ascertained (or where necessary developed), documented and understood. Controls are implemented to:
- seek risk (take opportunity);
- accept risk (where no further mitigating action is planned and the risk exposure is considered tolerable and acceptable);
- avoid risk (withdrawal from the activity that gives rise to the risk);
- transfer risk (either in part or in full to a third party which may be achieved through insurance, contracting, service agreements or co-production models of care delivery);
- or modify risk (put in place specific controls designed to change either the severity, likelihood or both).
Gaps in control are subject to action plans which are implemented to reduce residual risk.
v. Risk Reporting
All risks are recorded on the risk register. Significant risks (scoring 15 or above) are reported at each formal meeting of the Board of Directors. In addition, in the event of a significant risk arising, arrangements are in place to escalate a risk to the Chief Executive and Executive Team. The level at which risk must be escalated is clearly set out in the Risk Management Strategy. The risk report to the Board of Directors also details what action is being taken, and by whom, to mitigate the risk and monitor delivery. The Audit and Risk Committee have reviewed assurance on the effective operation of controls to manage potential significant risk. The Board of Directors has in place an up-to-date Board Assurance Framework which set outs the potential risks to the Trust's strategic objectives.
vi. Risk Review
Risks are reviewed at a frequency proportional to the residual risk which is detailed in the Risk Management Policy. Discretion regarding the frequency of review is permitted. As a minimum risks scoring over 15 are reviewed monthly. Those responsible for managing risk regularly review the output from the risk register to ensure it remains valid, reflects changes and supports decision making. Risk profiles for all Divisions are subject to detailed scrutiny as part of a rolling programme by the Risk and Compliance Group. The purpose of the Trust's risk review is to track how the risk profile is changing over time; evaluate the progress of actions to treat material risk; ensure controls are aligned to the risk; resources are reprioritised where necessary; and risk is escalated appropriately.

The Corporate Risk Register and Board Assurance Framework
Operational risk registers are maintained in wards and departments, and for time limited projects. Divisional registers consolidate directorate risks scoring 8 or above and any additional business risks to the division. Divisional registers are discussed in detail at the Divisional Patient Safety and Quality Board. The highest rated risks are taken to Risk and Compliance Group for review and consideration of action plans and the implementation of any plans. These risks are considered for escalation to the Corporate Risk Register.

Each board level director is responsible for their section of the Board Assurance Framework. The statements given in the framework are provided by the director who is accountable for the area. Directors are asked to consider and confirm the detail included in the framework. The Board Assurance Framework is linked to the Corporate Risk Register through a consideration of the risks on the risk register and the assurance statement included in the Board Assurance Framework.

The Risk and Compliance Group receives both the Board Assurance Framework and Corporate Risk Register and considers the detail included.

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

The Board of Directors reviews the Corporate Risk Register at each meeting and the Board Assurance Framework on a quarterly basis. The Quality Committee also reviews clinical risks on each of these eight times per year.

The Board Committees consider the Board Assurance Framework and the Corporate Risk Register when planning their agenda, and reference the Corporate Risk Register and Board Assurance Framework in their agenda.

The Board Assurance Framework has been reviewed and the document is aligned to the one year plan. This has strengthened the assurance systems and improved the system that links the risks and assurances to the strategies and objectives of the organisation.

Incident Reporting

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

- Adverse incident reporting - The Trust promotes a culture of openness and transparency and staff are advised on the Trust's approach to this through the Being Open /

Duty of Candour Policy. The key reporting systems the Trust uses are included in the Datix system. Use of the system provides an opportunity for the Trust to learn from incidents, together with complaints and claims and improve services.

- Serious incident reporting - The Trust has during the year continued to review and refine the Serious Incident investigation process. This has included the use of Director Review panels to assess the most serious incidents. Divisional panels are also held to assess moderate harm incidents and agree the most appropriate level of investigation. A Serious Incident Review Group, chaired by the Chief Executive and with senior clinical divisional representation, also reviews serious incidents and aims to ensure that cross divisional learning from serious incidents is taking place. The group also reviews national reports on learning from incidents and reviewed the Trust's response to the CQC report, Learning, Candour and Accountability

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

- Never events - The Trust experienced two never events during 2016/17 (two in 2015/16 and none in 2014/15). When there is a never event it is investigated in detail and the Trust aims to learn from the events. The results of these investigations are reported to the Quality Committee and the Board of Directors.
- Claims – The Trust has robust processes in place for dealing with both Clinical Negligence and Employers Liability Claims. When necessary we seek legal representation. A summary of any settled claim is disseminated where appropriate to:
  - involved clinician(s)
  - Relevant Clinical Director / Divisional Director
  - Directors
  - Health and Safety Team where appropriate

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

Learning from complaints is closely linked to learning from incidents that have caused severe or moderate harm. Having a culture where the expectation is to learn, no matter what happened is key, as well as involving patients and families. The work on learning from complaints will take place in the context of the recently developed framework on learning from adverse events, based on a staff survey and focus groups with staff on learning. This identified actions around the methods we use to share learning across the organisation, promoting a safety and learning culture and training. A session is planned with the nursing and midwifery committee in early 2017 to take this forward.

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

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

Trust Strategic Plan

In May 2016, the Board of Directors agreed the annual plan – setting out its key areas of delivery for year two of the five year plan. The plan aims to achieve the Trust vision of *'Together we will deliver outstanding compassionate care to the communities we serve'* and is built around the four goals of the Trust:

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

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

Transforming and improving patient care

- Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI.
- Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration) while keeping the base safe
- Failure to progress service reconfiguration caused by an inability to agree a way forward across health and social care partners
- Inability to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.
- Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care
- Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust

Keeping the base safe

- Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety
- Failure to implement robust governance systems and processes across the Trust
- The Trust does not deliver the necessary improvements required to achieve full compliance with NHS Improvemebt
- Failure to achieve local and national performance targets
- Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care

A workforce fit for the future

- Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
- Failure to attract and develop appropriate clinical leadership across the Trust.
- Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.
- Financial sustainability
- Failure to deliver the financial forecast position for 2016/17 due to non-delivery of cost improvement programmes, reduced activity and increased expenditure on additional capacity
- Failure to develop a robust financial plan for 2017/18 including identification of cost improvement programmes
- Failure to maintain cash flow

As at 31 March 2017 Calderdale and Huddersfield NHS Foundation Trust had identified a number of risks, which are being managed and mitigated, scoring 15 or above on the corporate risk register which could impact on the achievement of corporate objectives, compliance with its licence or CQC in the following areas:

- Progression of service reconfiguration impact on quality and safety
- Over-reliance on middle grade doctors in A&E
- Staffing risk, nursing and medical
- Delivery of Electronic Patient Record Programme
- Non delivery of 2016/17 financial plan
- Cash flow
- Urgent estates schemes not undertaken
- Environmental and estates issues within intensive care unit at Huddersfield Royal Infirmary.

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

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

Quality and financial governance

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

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

The Trust completed all of these actions. The ongoing deficit position and requirement for Secretary of State funding beyond 2016/17 means that the Trust is rated as level 3 under the Single Oversight Framework and has quarterly performance review meetings with NHS Improvement.

The Trust's five year strategic plan included a detailed review of the clinical, operational and financial challenges facing the Trust.

Clinical challenges;

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

Operational challenges;

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

Financial challenges;

- The Trust is reporting an underlying deficit of £27m for FY17.
- Provision of dual services across two sites is expensive, resulting from duplication of costs and the additional difficulties this presents in relation to recruiting and retaining staff.
- Both estates are expensive to run in terms of upgrade requirements and PFI contracts.

In addition, the Trust will be implementing an electronic patient record across the organisation in partnership with Bradford Teaching Hospitals NHS Foundation Trust. These risks are included on the Board Assurance Framework and the corporate risk register where appropriate.

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

At 31 March 2017 the Trust reported an income and expenditure deficit of £13.79m and a use of resources risk rating of 3, in line with plan. The Trust also delivered a cost improvement programme of £14.98m against the planned level of £14m.

Information governance

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

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

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

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

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

Confidentiality and information security awareness training is provided to all staff in the Trust's Induction Programme and through mandatory annual Information Governance training which is monitored by the Board through the Integrated Board Report. Training is also targeted at specific areas or staff groups on a risk basis. Progress with Information Governance compliance is measured on a yearly basis through the Trust's self-assessment against the Connecting for Health Information Governance Toolkit.

The organisation has a well-tested disaster recovery plan for data which aims to ensure that data, and access to data is not compromised or vulnerable at a time of any unexpected system downtime. Detailed reviews are undertaken following any incidence of systems failure and learning shared across systems.

All staff are governed by the NHS code of confidentiality, and access to data held on IT systems is restricted to authorised users. Information governance training is incorporated into the statutory/mandatory training programme and supplemented as appropriate in all IT training sessions.

Information risks have been a significant area of focus in 2016/17 as the Trust works towards the implementation of the new electronic patient record early in 2017/18.

There have been two Information Commissioner's Officer (ICO) reportable (at level 2) incidents in the last 12 months relating to information security. The first, reported in September 2016 being the temporary loss of paper based patient data. The second related to inappropriate access using Trust equipment and systems. This incident was reported to the ICO in December 2016 and the ICO requested a copy of the findings of the Trust's investigation.

As a result of both of the incidents the Trust sent an all user email to all staff to ensure that they read the Trust's IG Policies as a matter of urgency, in addition to the message was to ensure awareness of the correct use of Trust IT equipment.

Reminder messages were sent to staff regarding:

- Appropriate use of patient IT systems
- Ensuring all staff are aware of security of their passwords; smartcards and log ins
- Ensuring all staff are aware and have read and understand the Trusts IG Policies
- Ensuring all staff are up-to-date with their mandatory IG Training

The Trust complies and has attained level 2 or greater, with all the requirements of the Information Governance Toolkit.

Care Quality Commission

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

- reporting and keeping under review matters highlighted within inspections;
- liaising with the Care Quality Commission Compliance Inspectors and divisional senior clinicians and managers in response to any specific concerns that are raised with the Care Quality Commission by patients and members of the public;
- engaging with the Care Quality Commission Compliance Inspectors on the inspection process and co-ordinating the Trust's response to inspections and any recommendations or actions that arise;
- analysing trends from incident reporting, complaints, and patient and staff surveys and sharing the learning from these across the Trust;
- reviewing assurances on the effective operation of controls;
- receiving details of assurances provided by Internal Audit and any clinical audit conclusions which provide only limited assurance on the operation of controls; and
- challenging assurances or gaps in assurance through chairing the Risk and Compliance Group

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

The CQC carried out an inspection of the trust between 8th and 11th March 2016 as part of their comprehensive inspection programme.

In addition, unannounced inspections were carried out on 16th and 22nd March 2016. The Trust was rated as requires improvement overall.

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

These reports included a narrative to support the judgements that were made for each of the key questions and included a list of actions that the Trust must do take to improve quality and safety of care, and a further list of actions that the Trust should take. These were considered against the specific regulations set out in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the associated fundamental standards.

The inspection team provided positive feedback about infection control policies and practice and patient's ability to access suitable nutrition and hydration including special diets.

A positive incident reporting culture was noted and adherence to duty of candour principles.

Examples of outstanding practice were also noted including:

- The development and growth of the ambulatory care service
- Use of engagement support workers to engage and socialise as well as providing cognitive and physical support to patients with dementia and/ ore delirium
- Development of recognising deteriorating patients and Nerve Centre technology to support identification and escalation of deteriorating patients
- A proactive and energised discharge team

Final ratings for the Trust							
	Safe	Effective	Caring	Responsive	Well-led		Overall
Overall	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement		Requires Improvement

The report set out 19 must do actions and 12 should do actions. Some of these were detailed as requirement notices that cross referenced to 3 CQC regulations.
The requirement notices were in relation to:

- Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment
  - Regulation 12 (1) Care and treatment must be provided in a safe way for service users

- Regulation 17 HSCA (RA) Regulations 2014 Good governance
  - Regulation 17 (1) Systems and processes must be established and operated effectively to: (2) (a) assess, monitor and improve the quality and safety of services; (b) assess, monitor and mitigate the risks relating to the health, safety and welfare of service users; (c) Maintain securely and accurate, complete and contemporaneous record of care; (e) seek and act on feedback from relevant persons and other persons on the services provided for the purpose of continually evaluating and improving such services

- Regulation 18 HSCA (RA) Regulations 2014 Staffing
  - Reg. 18 (1) There must be sufficient numbers of suitably qualified, competent, skilled and experienced staff on duty.
  - Reg. 18 (2) (a) Persons employed by the service provider in the provision of the regulated activity must receive such appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out duties they are employed to perform.

The Trust put in place an action plan to address the must do and should do actions detailed in the final report some of which impacted on all Divisions and others which were specific to a core service and impacted on an individual division. In addition divisions had individual improvement and sustainability plans made up of issues raised in the core service reports and those actions required to ensure services sustained the good practice observed at the time of the CQC inspection.

The action plan set out:

- The associated CQC domain and whether the action is relevant for all services or a specific core service.
- The issue / issues raised by the CQC that led to the action
- The expected outcomes (measurable)
- The lead director / manager / governance committee

A blue / red / amber / green rating was applied to each of the actions within the plan, using the framework below:

Delivered and sustained
Action complete
On track to deliver
No progress / not progressing to plan

In order for an action to become green, robust evidence is required as assurance that:
- The action has been completed
- The action will achieve the intended impact
- Any identified risks are captured on the risk register
- There is a plan in place to monitor the effectiveness of the actions, including the impact for patients / staff

In order for an action to become blue, a period of monitoring / measuring must be completed which demonstrates a sustained delivery of the expected outcome.

A detailed plan was developed for each of the must and should do actions. The delivery of the plan has been overseen by a CQC Response Group with regular updates from management leads against the agreed timescales. Reports on progress have been provided monthly to the Trust Executive Board, the Quality Committee and the Board of Directors. Progress has also been discussed with commissioners and the CQC Inspection Managers via regular relationship meetings.

As at 31 March 2017 all but four actions had been delivered and sustained. The four remaining actions were complete and required further time to be embedded.

Examples of improvements that have been made so far:

- Governance processes have been strengthened at Divisional and ward level with increased support from the corporate Risk and Governance Team and more robust quality and assurance arrangements at ward and department level. A particular focus has been to maximise learning from adverse events, with colleague engagement events held to appreciate preferred methods of learning and to identify the current barriers to learning. (Well Led)
- The Trust's approach to improved staffing has been strengthened with a number of initiatives introduced to increase staffing in both the nursing and medical

workforce. (Well Led, Safe, Effective)
- A significant improvement has been achieved in the timeliness of complaint responses (Well Led, Effective)
- Maternity services have strengthened their approach to receiving and responding to feedback from women, greater engagement with service users is seen as key to the success of this (Safe, Caring, Effective)

Many of the projects have now evolved and will become part of additional improvement work in 2017/18. This will be monitored through the Risk and Compliance group which reports to Audit and Risk Committee.

Compliance with the NHS foundation trust condition 4

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

A prioritised action plan was developed for delivery over a 12 month period and was monitored through the Trust's monthly performance review meetings with NHS Improvement. The actions included:
- Development of a risk management culture and processes;
- Implementation of a performance management framework;
- Development of data quality kite mark;
- Sharing of lessons learned.

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

These actions and the assurance processes described in this statement allow the Board to issue an accurate Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b) of NHS Improvement's provider licence.

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

Communication with stakeholders

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

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

Examples of the forums and methods of communication with stakeholders are as follows:

Council of Governors (known as the Membership Council)
The Membership Council has a formal role as a stakeholder body for the wider community in the governance of the Trust. The Membership Council during 2016/17:
- Held four meetings during the year
- Held working groups to consider issues such as reconfiguration of the hospital services, annual planning and the Quality Report.
- Ensured there was communication with members through a regular newsletter and open events including the Annual General Meeting
- Received regular reports on the activities of the Trust
- Participated in divisional reference groups to look at the work of the divisions and risks facing the divisions in detail.

Staff
- Monthly Trust News and weekly e-bulletin 'CHFT Weekly'
- Monthly team briefing – Big Brief
- Staff surveys
- Ad-hoc emails from the Chief Executive
- Intranet banners and screen savers
- Consultation on the reconfiguration of hospital services
- Staff Family and Friends test

Public and service users
- Patient surveys and experience feedback
- Focus groups
- Family and Friends test
- Healthwatch
- Participation in the formal public consultation on the reconfiguration of hospital services.

Other organisations
- West Yorkshire Association of Acute Trusts
- West Yorkshire Sustainability and Transformation Partnership
- Quarterly GP Newsletter
- Forums and formal meetings with other health and social care organisations such as the System Resilience Group
- GP Federation meetings
- Board to board meetings with other local trusts
- Clinical and professional network groups
- Calderdale and Kirklees Health Overview and Scrutiny Committees
- Calderdale and Kirklees Health and Wellbeing Boards

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

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

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

Climate change and adaptation reporting requirements under the Climate Change Act 2008
Calderdale and Huddersfield NHS Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

A Sustainable Development Group including Executive and Non-Executive directors overseas the Sustainable Development Action Plan that is used to target specific areas within the broader sustainability agenda such as recycling and more sustainable travel.

Review of economy, efficiency and effectiveness of the use of resources

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

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

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

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

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

The resources of the Trust are managed through various measures, including the adoption of a robust budgetary control system, the consistent application of internal financial controls and effective procurement and tendering procedures.

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Trust has at its disposal. Assurances on the operation of controls are commissioned and reviewed by the Audit and Risk Committee and, where appropriate, the Quality Committee or other 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.

Annual Quality Report

The board of directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

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

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

There is clear clinical leadership for the development of the Annual Quality Report each year by the Executive Director of Nursing, in close collaboration with the Executive Medical Director. Both the Quality Committee and the Membership Council receive assurance on the progress against the priorities and outcomes highlighted within the Annual Quality Report. The Quality Committee is responsible for overseeing the production of the Annual Quality Report and for overseeing monitoring indicators and data quality. The Trust has engaged with its membership to develop the shortlist of quality priorities for 2017/18 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. Last year the external audit made two recommendations based on their review of the indicators:

- 18 week indicator: It was recommended that the Trust review its validation methodology. This recommendation was accepted. The Trust put in place quarterly spot checks as an interim measure as with the implementation of the new electronic patient record, data quality checks are built in to the system.
- Complaints: It was recommended that the initial contact with the complainant within seven days of receipt of the complaints should be recorded in the notes. This recommendation was accepted and the initial date of contact is recorded and checked.

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

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

During 2016/17 a key area of focus was the implementation of actions resulting from the Care Quality Commission inspection in March 2016 following the receipt of the report in August 2016. Progress on these actions was monitored via a CQC Response Group which reported to the Quality Committee. The Quality Committee reviewed evidence for each action to assess that the action had been completed and embedded.

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. The Trust has procured an electronic patient record which will be implemented during the first quarter of 2017/18. 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. This includes strengthening the controls relating to the quality and accuracy of waiting time data.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the 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. The Committee also ensures that the Trust is meeting its corporate compliance requirements through a regular review of the compliance register, and has oversight of expressions of concern and whistleblowing arrangements. The Finance and Performance Committee is chaired by a Non-Executive Director and reports to the Board of Directors.

Quality Committee

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

Finance and Performance Committee

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

Internal Audit
During 2016 the internal auditor has merged with another provider to form Audit Yorkshire. The arrangements for internal audit have not changed as a result of this merger. 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 22 reports with significant or full assurance. 12 internal audits received limited assurance. These were: General Office - Cash Handling; Patient Appliances; Discharge Planning; Information Governance Toolkit; Payroll; Carter Review Efficiencies; Theatre Stores; Complaints Handling; Radiology Reporting; Agency and Bank Staff; and Controlled Drugs Stationery.

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.

External Audit
External audit provides independent assurance on the accounts, annual report, Annual Governance Statement and on the Annual Quality Report.
These documents and internal and external audits of specific areas of internal control provide the Board of Directors with the information it requires to gain assurance that the Trust is meeting its objectives to protect patients, staff the public and other stakeholders against risks of any kind: which allows the Board to support me in signing this Annual Governance Statement.

Significant matters in-year

The Trust had a number of significant matters during 2016/17:

- Like many other Trusts, we had significant challenges in the Emergency Care total time in A&E to be under four hours and we did not meet the national requirement for 95% of patients to be seen in A&E within 4 hours, achieving 94.4%. Achievement of the target was impacted upon by A&E attendances increasing during 2016/17 by 2.5% - 3,700 on the same period in 2015/16, and difficulty in discharging patients at both sites.
- Our two local Clinical Commissioning Groups undertook public consultation on the reconfiguration of hospital services. The Trust supported this consultation process which had significant local and regional public and political interest.
- Recruitment and retention of medical staff into key specialties continues to be a challenge and has led to continued bank and agency use. The introduction of IR35 legislation has since placed additional pressure in particular specialties. A contingency plan has been developed for emergency care should gaps in staffing mean put the safety of the service at risk.
- The Trust has continued to undertake significant nursing recruitment both nationally and internationally. This has been successful however the need to open to additional capacity over the winter period placed pressure on nurse staffing which had to be addressed through bank and agency use.
- During 2016/17 the Trust prepared for the implementation of a new electronic patient record. This included significant operational and technical preparation including training around 5000 staff on the new system in readiness for go-live in April 2017.
- There were 74 reported serious incidents and two never events 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 2017 and up to the date of approval of the annual report and accounts.

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

Owen Williams
Chief Executive
23 May 2017

Independent auditor's report

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

Opinions and conclusions arising from our audit

1. Our opinion on the financial statements is unmodified

We have audited the financial statements of Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2017. These financial statements comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in 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 Trust's affairs as at 31 March 2017 and of the Trust's income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Department of Health's Group Accounting Manual 2016/17.

Overview		
Materiality: Financial statements as a whole	£3.7m (2015/16:£3.5m) 1% (2015/16: 1%) of total income from operations	
Risks of material misstatement		**vs 2015/16**
Recurring risks	Valuation of Property, Plant & Equipment	◀▶

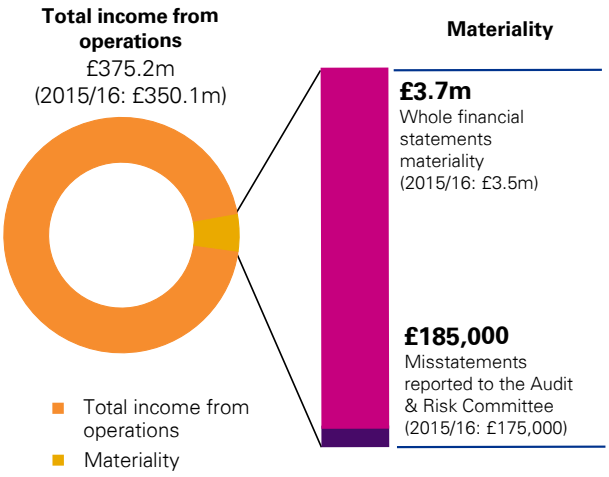
2. Our assessment of risks of material misstatement

In arriving at our audit opinion above on the financial statements, the risk of material misstatement that had the greatest effect on our audit, is as follows (unchanged from 2015/16):

	The risk	Our response
Property, Plant & Equipment (£234 million; 2015/16: £217m) *Refer to the Audit & Risk Committee Report within the 'Directors' Report') in the Trust's Annual Report and Accounts, Section 1.5 of Note 1 to the Accounts (accounting policies) and Note 16.1 to the accounts (Property, Plant & Equipment disclosures).*	**Valuation of land and buildings** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to Calderdale Royal Hospital in Halifax and Huddersfield Royal Infirmary. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset. When considering the cost to build a replacement asset the Trust consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic. Generally valuations should be gross of VAT. However, circumstances may arise where the asset would be more appropriately valued net of VAT. For instance, entities may recover VAT on payments for the provision of a fully managed and serviced building under a PFI. The valuation of the land & buildings is completed by the District Valuer, an external expert engaged by the Trust, using construction indices and so accurate records of the current estate are required. Full valuations are required to be completed every five years, with interim desktop valuations completed in interim periods. Valuations are inherently judgmental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. Calderdale & Huddersfield NHS Foundation Trust had a full valuation undertaken at 31 March 2015, and an interim valuation performed at 31 March 2017. The result of the valuation at 31 March 2017 was an increase of £4 million in the value of the land & buildings.	Our procedures included: — **External valuer:** We critically assessed the scope, qualifications and experience of the Trust's external valuer to confirm they were appropriately experienced and qualified to undertake the valuation, and we considered whether the overall valuation methodology was in line with industry practice, the Department of Health Group Accounting Manual and the Trust's accounting policies; — **Completeness of the valuation data:** We considered whether the information provided to the valuer by the Trust, relating to the assets requiring to be valued, including details of in-year capital expenditure, changes in use and land area and floor space, was complete and agreed to the Trust's fixed asset records; — **Valuation assumptions:** We critically assessed the appropriateness of the assumptions used in the valuer's calculations, especially cost indices and underlying replacement cost assumptions, based on our own expectations by reference to sector and local knowledge; — **Accounting treatment:** We reviewed the treatment of the revaluation within the Trust's financial statements to ensure that any upwards revaluations or impairments had been properly classified and accounted for and complied with the requirements of the Group Accounting Manual; and — **Additions:** We tested a sample of items of capital expenditure in 2016/17 to confirm that the additions were appropriately valued in the financial statements.

3. Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £3.7 million (2015/16: £3.5 million), determined with reference to a benchmark of income from operations (of which it represents approximately 1%). We consider income from operations to be more stable than a surplus-related benchmark. We report to the Audit & Risk Committee any corrected and uncorrected identified misstatements exceeding £185,000 (2015/16: £175,000), in addition to other identified misstatements that warrant reporting on qualitative grounds.



4. Our opinion on other matters prescribed by the Code of Audit Practice 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 2016/17; and
- the information given in the Annual 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 matters on which we are required to report by exception

We are required to report to you if, based on the knowledge we acquired during our audit, we have identified 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; or
- the Audit & Risk Committee's commentary in the Directors' Report in the Annual Report does not appropriately address matters communicated by us to the Audit & Risk Committee.

Under the Code of Audit Practice 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 2016/17, 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.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

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

Under the Code of Audit Practice we are required to report to you by exception if we are not satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In January 2015, Monitor issued enforcement undertakings under section 106 of the Health and Social Care Act 2012. Monitor stated that it had reasonable grounds to suspect that the Trust has provided and is providing healthcare services for the purpose of the NHS in breach of the following conditions of its licence:

- CoS3(1) – Continuity of service licence conditions in relation to standards of Corporate Governance and Financial Management; and
- FT4(2), FT4(4), FT4(5)(a)(c)(d) and (f) – NHS Foundation Trust licence conditions in relation to Governance Arrangements.

KPMG

The Trust have made progress in addressing the enforcement undertakings, however the enforcement undertakings and modifications of the licence remained in place throughout 2016/17. The breaches are evidence of weaknesses in proper arrangements for delivering sustainable resource deployment and informed decision making.

Except for the matters referred to above we are satisfied that the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

7. We have completed our audit

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

Scope and responsibilities

As described more fully in the Statement of Accounting Officer's Responsibilities the accounting officer is responsible for the preparation of financial statements that 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. 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 Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General, as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

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.

Clare Partridge for and on behalf of KPMG LLP
Chartered Accountants and Statutory Auditor
1 Sovereign Square, Sovereign Street,
Leeds, LS1 4DA

25 May 2017

KPMG


Calderdale NHS
Welcome to
Brighouse
Health Centre

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Quality Account

2016/17

compassionate care

Part 1: Chief Executive's Statement

Welcome to the 2016/17 Calderdale and Huddersfield NHS Foundation Trust (CHFT) Quality Account.

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

In August 2016 we received the CQC inspectors' report following an intense inspection in March 2016.

We were pleased that the pride of CHFT colleagues in their work caring for our patients and their families was singled out for praise by the inspectors and in most areas the care we provide was rated as good. Overall the Trust's rating was "requires improvement" which is in line with all other West Yorkshire trusts. We had already identified and were already working on some areas and this will continue on into the future. At the time of writing we are awaiting the inspectors' follow-up visit and hope to demonstrate and impress them with the developments we have made.

Providing 'Compassionate Care' and putting our patients first continues to be a high priority for all of our staff and the Trust. That was very much the main case for change when the reconfiguration process was launched last summer. In October, after a consultation process locally, our clinical commissioning groups (CCG) partners backed the plans to reconfigure healthcare in hospitals and community setting across Calderdale and Greater Huddersfield with a view to improving quality and safety.

The Trust is now in the process of producing the detailed Full Business Case (FBC) which provides more detail about how we achieve that end result and that should be published later this year for more consideration.

As I write, we are emerging from the most challenging NHS winter ever and this has certainly brought all the services we provide here in our two hospitals and in the community into focus. Throughout, I can report, CHFT responded to the challenges extremely well and compared to the rest of the country in terms of performance for our patients we were always very well placed. When other Chief Executives ask me how we managed this, at times of such pressure, my answer is always the same and simple. It's all down to my 6,000 colleagues at CHFT. At this point I would also give our partners in social care a mention as, without us all being joined up and working well together, the service CHFT provides would not be as good as it is.

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

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

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

Owen Williams, Chief Executive, 23 May 2017

Part 2: How the Trust performed against the three priorities set for 2016/17

Each year the Trust works on a number of quality priorities. Last year the Trust identified three projects to be highlighted as key priorities for 2016/17.

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

Improvement Domain	Improvement Priority	Were we successful in 2016/17?
Safety	Falls (Introduction of Safety Huddles)	Yes
Effectiveness	Implementation of Hospital out of Hours (HOOP)	Yes
Experience	Understanding the Community Experience	Yes

Priority One – Falls and the implementation of Safety Huddles

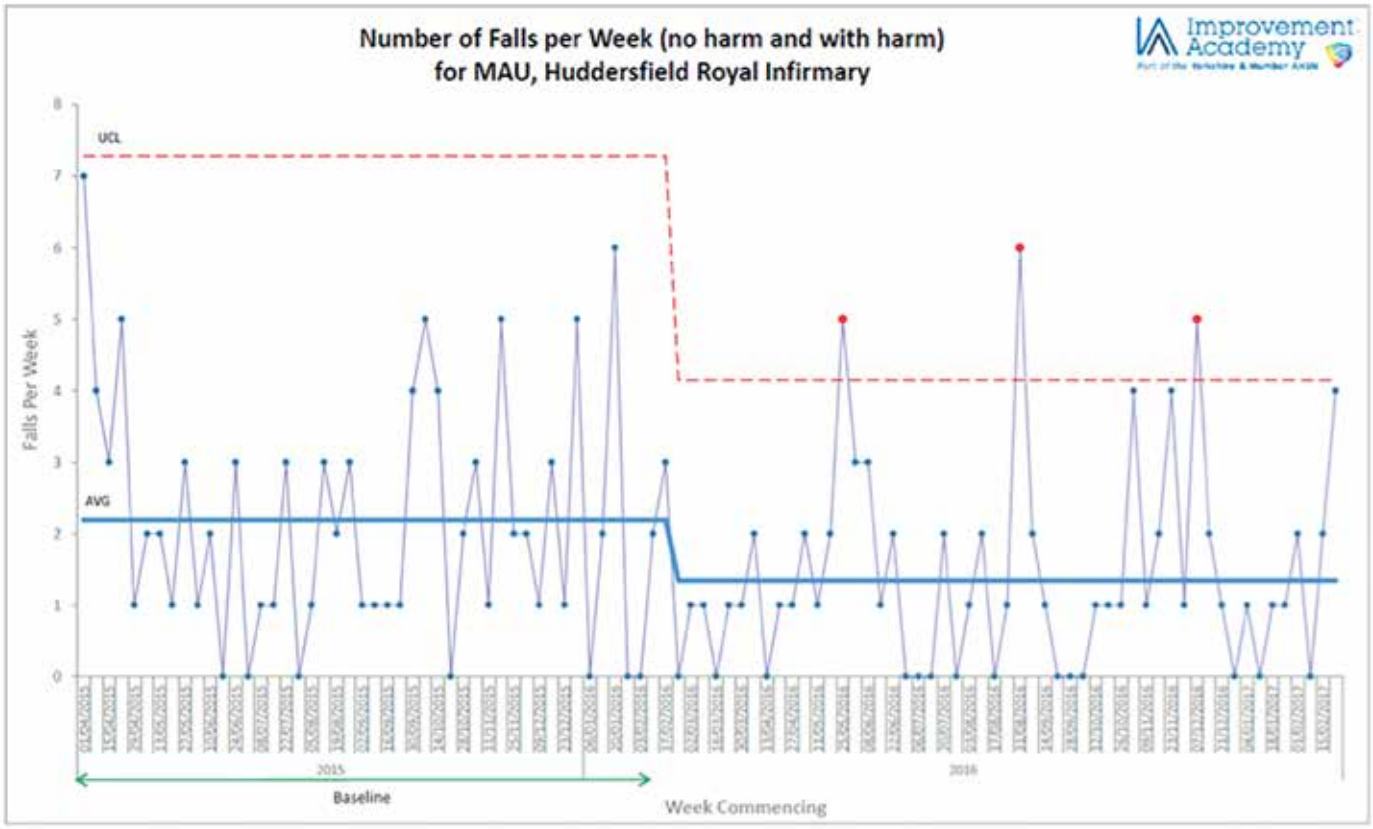
Why we chose this

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2013, 2014). Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.

During 2015/16 The Trust had been monitoring the number of falls each year but did not see any reduction in the reported numbers each month. As such the Trust engaged with the local Improvement Academy and sought their expertise in the delivery of "safety huddles".

Safety huddles are about integrating multi professional huddles into routine clinical care as part of a systematic approach to reducing harm. Safety huddles, led by senior consultants, involve all levels of staff and provide important space for discussion of patient safety issues. Safety huddles are about more than just reducing falls and instead target a reduction in all harm events through better team working and awareness.

Early success was seen in the Medical Assessment Unit in Huddersfield Royal Infirmary, which led to huddles, are being trialled across the medical wards. These are expected to become embedded practice in 2017/18. Internal targets of having huddles on at least eight inpatient ward areas were met. Some wards have already begun to show improvement such as the Medical Assessment Unit (MAU) at HRI, shown below. The impact on the number of falls trust wide should become more evident in 2017/18.



Priority Two – Improving Response to Deterioration (Mortality Reduction)

Why we chose this
Understanding hospital mortality is a key area for any acute trust. The Trust has been undertaking retrospective case note reviews on inpatient deaths since 2013. Some of the learning has highlighted the need to be more responsive to those patients who may experience deterioration in their condition during the evening and early morning hours.

Target
The Trust aims to see improvement in the time taken to respond to patients who may deteriorate during the evening and early morning hours. Once the system is in place, baseline measures will be gathered and ongoing performance monitored.

Improvement work
During 2016/17 the aims of the project were to have a fully implemented Hospital at Night module during evening hours. This involved the recruitment of additional staff to provide the care needed by patients.

Reporting
The system went live at Calderdale Royal Hospital, CRH, on 14th September 2016 and has run fully in all out of hours periods including bank holidays since then. There has been no down time and no system failures or significant issues. Evaluation at CRH gave early data on the system and feedback from users at CRH was generally positive. Implementation data is generated on a monthly basis showing volumes of tasks, types of tasks and workload of different staff groups. Individual tasks can also be analysed and this is being used to help investigate incidents raised via Datix, as well as pulling through confounding factors from the shift relevant to the incident, such as volume of work and acuity of patients requiring attention.

The Hospital at Night programme was re-named the Hospital Out of Hours Programme (HOOP) in the summer of 2016. The system went live at HRI on 1st February 2017 and is in place for out of hours care between 5pm and 8am Monday to Thursday and Friday 5pm to Monday 8am at both sites. All posts in the HOOP team are now filled.

Phase 1 has focussed on the introduction of the electronic task management system within NerveCentre, with a team of clinical co-ordinators in place which triages tasks and allocates these to the most appropriate healthcare professional and responds to raised National Early Warning Score (NEWS) alerts. Evaluation of phase 1 is planned for April / May 2017.

During 2017/18 work will continue, bringing HOOP and deteriorating patient work together, using both the electronic patient record IT system, EPR which is being introduced in May 2017 and HOOP in the recognition and response to deteriorating patients in and out of hours.

Priority Three – Improving Community Services

Why we chose this
Community services can be complex and diverse, with many patients accessing a number of different services multiple times. The Trust has been using the Community Friends and Family Test (FFT) since April 2014. During 2015/16 improvements were made to the response rate but ended with just over 11% of patients engaging in this process. Alongside this limitation, the feedback mechanisms did not enable gaining deep insight into the views of those patients who may be less satisfied with our services than we would like.

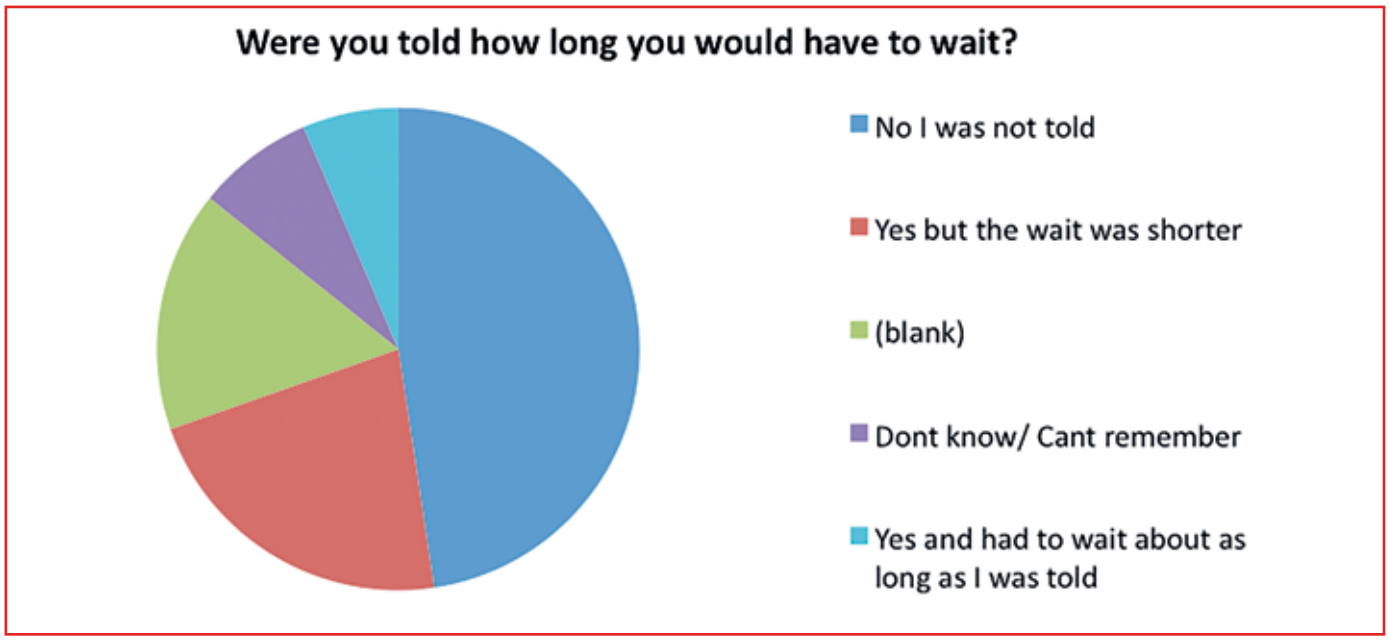
Improvement work
In order to gain insight into these diverse services, it was decided to develop additional feedback mechanisms to illustrate where improvement could be made and how we can best support this client group. The Trust aimed to get feedback regarding a number of different community settings and each quarter targeted a new area. The areas were chosen through the use of local intelligence from any complaints, Friends and Family (FFT) comments and/or any concerns raised by staff to ensure we are looked at the areas that we could most learn from.

Reporting
The development of the first survey, looking into Physiotherapy Outpatients took place in Q1 (April 2016-June 2016). A web based survey was designed (based on the NHS National Outpatient Questionnaire) and tested for use which was then distributed during Q2.

The Physiotherapy Outpatient team operates from a number of sites, both hospital and community sites across Calderdale and Huddersfield. In 2015/16 the service received 27746 new patient referrals with patient facing contacts of 19261 new appointments and 51030 follow-ups.

The service has continually rated as red on the FFT due to consistently reporting a percentage of patients who said they 'wouldn't recommend' the service in excess of 2.5%.

Data collection started on 1st September 2016, and by 30th September 2016 there had been 657 responses. Analysis of the data showed that in the main, experience was positive. The only area where potential improvement could be made was regarding being informed about waiting times.



Examples of comments received were:

"Staff really listen to you and explain everything."

"Waiting room is extremely quiet. Music is required there."

"Very caring and professional staff. Explained everything and gave time for me to ask any questions"

"Good option of appointment times. Seems better than when I visited about 5 years ago. Brilliant that they have classes and equipment too"

"I have been more than happy with everything and staff are understanding they have helped me in every way all and always puts my needs forward"

"The level of care by the physiotherapist was excellent. Assistance given by the physiotherapy department as a whole has also been excellent"

The orthotics service was identified as the second service for data collection. The team operates from HRI and the equipment store at Salterhebble. In 2015/16 the service received 2663 new patient referrals.

During quarter 3 a web based survey was developed for use with patients attending an Orthotic clinic.

The service used a questionnaire that was based on the one used by the out-patient Physiotherapy service.

The data was collected throughout December 2016 and by 6th January 2017 there had been 67 responses.

Looking ahead to 2017/18

A 'long list' of potential priorities for 2017/18 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 2016/17,
- Membership Council workshop.

This long list was discussed with the Trust's Membership Council; an opportunity to vote was also given via the Trust's internet site advertised in Foundation Trust News which is circulated to the Trust membership. This work has helped identify the following quality improvement priorities for 2017/18.

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

The three priorities for 2017/18 are:

Domain	Priority
Safety	Sepsis Screening
Effectiveness	Discharge Planning
Experience	Learning from Complaints

Priority One – Sepsis Screening for in patients

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

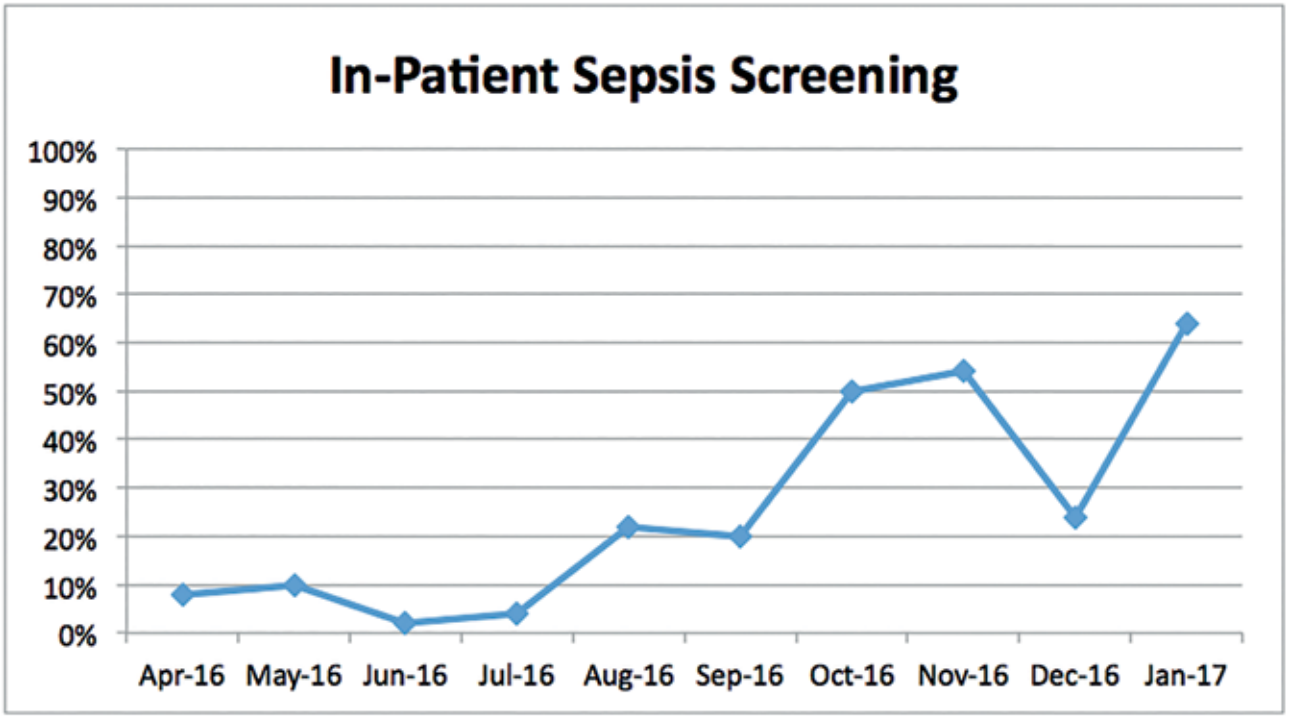
Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. Problems in achieving consistent recognition and rapid treatment of sepsis are thought to contribute to a number of preventable deaths.

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

Work in 2016/17 saw reliable processes embedded for emergency admissions. Whilst improvements were seen in screening those patients who were at risk of developing sepsis during their hospital stay, there is still more to be done.

Target
The Trust will look to achieve improvements in the identification of patients who are at risk of developing sepsis during their inpatient stay.

Improvements were made in 2016/17 but the aim would be to see 90% of appropriate patients screened.



Reporting
The Trust will continue to monitor performance through the monthly Integrated Performance Report. Ongoing progress will be managed and reported through the Sepsis Improvement Group.

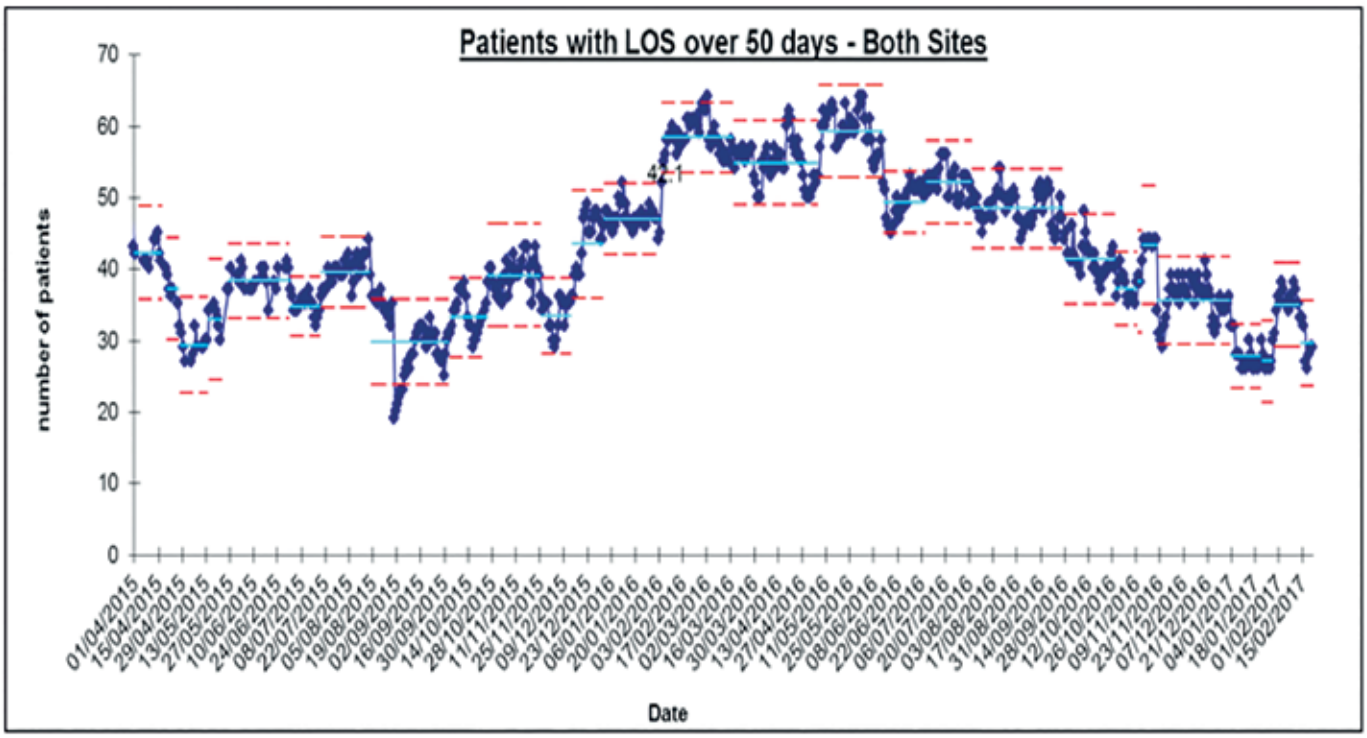
Priority Two – Discharge Planning

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

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

The work in 2017/18 is a continuation of a transformational piece of work started by the Trust in 2016/17 and has robust metrics attached.

Target
The Trust will measure the number of patients occupying a bed for more than 50 days. Whilst some of these patients will have a medical need for a long stay in hospital, experience tells us that most will be medically fit and awaiting help or support at home. Because of this, the total number is a key metric.



Reporting
The metrics for this work are reviewed monthly by the Safer Patient Board, and will be shared with the Quality Committee on a quarterly basis.

Priority Three – Learning from Complaints

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

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

Learning from complaints is closely linked to learning from incidents that have caused severe or moderate harm. Having a culture where the expectation is to learn, no matter what happened is key as well as involving patients and families. The work on learning from complaints will take place in the context of the recently developed framework on learning from adverse events, based on a staff survey and focus groups with staff on learning. This identified actions around the methods we use to share learning across the organisation, promoting a safety and learning culture and training. A session is planned with the nursing and midwifery committee in early 2017 to take this forward and ensuring that learning from complaints feeds into this work is key, with plans for the Complaints Manager to be a member of an editorial board for key communications to staff on current topics identified through learning.

We are awaiting an internal audit report on learning from complaints that was undertaken in February 2017. Once this is received we will agree actions in response to the recommendations to improve how we learn from complaints.

Target
Increase in the number of staff trained in complaints management.
Delivery of agreed recommendations on learning from internal auditors report on complaints.

Reporting
The metrics for this work are reviewed quarterly by the Patient Experience Group (PEG), and the Trust Patient Quality and Safety Board (PQSB).

Statements of assurance from the Board

Review of services
During **2016/17** Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 36 designated Commissioner Requested Services'.

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

The income generated by the relevant health services reviewed in 2016/17 represents 100% of the total income generated from the provision of relevant health services by Calderdale and Huddersfield NHS Foundation Trust for 2016/17.

Participation in clinical audit
Clinical audit is both an assurance process and an opportunity to make improvements and the Trust embraces these opportunities.

During 2016/17, 41 of the national clinical audits and 4 national confidential enquiries covered relevant NHS services provided by Calderdale and Huddersfield NHS Foundation Trust.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 97.56% of national clinical audits and 100% of national confidential enquiries which it was eligible to participate in. These are detailed in Appendix A.

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

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2016/17 that were recruited into trials during that period to participate in research approved by a research ethics committee was 2532.

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 stays abreast of the latest possible treatment possibilities and active participation in research leads to improved patient outcomes.

The Trust was involved in conducting 168 clinical research studies of which 81 were actively recruiting (excludes student and Participant Identification Centre - PIC studies), 39 were closed to recruitment (but participants were still involved) and 11 studies were 'in set up' (either waiting for initiation or local approval).

During 2016/17 actively recruiting research studies were being conducted across four of the five divisions in twenty five specialties:

- Families and Specialist Services (14 studies, 9 specialties);
- Corporate (3 studies);
- Medical Services (59 studies, 11 specialties);
- Surgical and Anaesthetic Services (5 studies 5 specialties).

There were 63 clinical staff participating in research approved by a research ethics committee at the Trust during 2016/17, of which 50 were local principal investigators, 2 were chief investigators on qualitative studies, 1 was chief investigator on a collaborative laboratory study and 1 was chief investigator on a device study. There was 1 clinician commencing, and a further 4 continuing their studies at doctoral level.

Also, in the last three years, two 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 2016/17 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 2016/17 was £6.98 million.

The CQUIN areas identified for 2016/17 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.

Three national CQUIN areas were identified for 2016/17:
- Sepsis – Screening and antibiotic administration
- Antimicrobial Resistance
- Staff Well Being

These national areas were complemented by further locally agreed CQUIN indicators in the following areas:
- Self-Management of Medications
- Safety Huddles
- Improving community experience

The Trust did not achieve the full target for the Sepsis CQUIN 2016/17 or the full 1% reduction in Antibiotic Prescribing. However partial achievement was noted. The Trust had a year-end settlement with its main commissioners, NHS Calderdale CCG and NHS Greater Huddersfield CCG which included a small reduction in CQUIN funding for non-achievement. Across the main commissioners, Associate CCGs and NHS England the CQUIN funding withdrawn due to partial achievement was £0.06m. The value of CQUIN achieved in 2016/17 therefore was £6.92m.

A similar agreement was made in relation to CQUIN achievement in 2015/16 where the Trust did not achieve the full target for the Sepsis CQUIN 2015/16 or the AKI CQUIN. However partial achievement was noted. The Trust had a year-end settlement with NHS Calderdale CCG, NHS Greater Huddersfield CCG and NHS England, no withdrawal of CQUIN funding for non-achievement was made in 2015/16.The value of CQUIN therefore achieved in 2015/16 was £6.8m.

Seven national CQUIN areas have been identified for acute trusts in 2017/18, alongside three national CQUIN for providers of community services.

CQUIN		Community or Acute
1.	Improving Staff Health and Wellbeing	Acute
2.	Reducing the impact of serious infections (Antimicrobial resistance and Sepsis)	Acute
3.	Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI)	Acute
4.	Improving services for people with mental health needs who present to A&E	Community
5.	Offering Advice and Guidance	Acute
6.	e-Referrals	Acute
7.	Supporting proactive and safe discharge	Acute
8.	Preventing ill health by risky behaviours – alcohol and tobacco	Acute
9.	Improving the assessment of wounds	Community
10	10.Personalised care and support planning	Community

Further details of the nationally agreed goals for 2017/18 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

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

The CQC carried out an inspection of the trust between 8th and 11th March 2016 as part of their comprehensive inspection programme.

In addition, unannounced inspections were carried out on 16th and 22nd March 2016. The Trust was rated as requires improvement overall.

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

These reports included a narrative to support the judgements that were made for each of the key questions and include a list of actions that the Trust must take to improve quality and safety of care, and a further list of actions that the Trust should take. These were considered against the specific regulations set out in The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the associated fundamental standards.

The inspection team provided positive feedback about infection control policies and practice and patient's ability to access suitable nutrition and hydration including special diets.

A positive incident reporting culture was noted and adherence to duty of candour principles.

Examples of outstanding practice were also noted including:
– The development and growth of the ambulatory care service
– Use of engagement support workers to engage and socialise as well as providing cognitive and physical support to patients with dementia and/or delirium
– Development of recognising deteriorating patients and Nerve Centre technology to support identification and escalation of deteriorating patients
– A proactive and energised discharge team

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

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

Action Plan
A detailed plan was developed for each of the must and should do actions. The delivery of the plan has been overseen by a CQC Response Group with regular updates from management leads against the agreed timescales. Reports on progress have been provided monthly to the Trust Executive Board, the Quality Committee and the Board of Directors. Progress has also been discussed with commissioners and the CQC Inspection Managers via regular relationship meetings.

Examples of improvements that have been made so far:
– Governance processes have been strengthened at Divisional and ward level with increased support from the corporate Risk and Governance Team and more robust quality and assurance arrangements at ward and department level. A particular focus has been to maximise learning from adverse events, with colleague engagement events held to appreciate preferred methods of learning and to identify the current barriers to learning. (Well Led)
– The Trust's approach to improved staffing has been strengthened with a number of initiatives introduced to increase staffing in both the nursing and medical workforce. (Well Led, Safe, Effective)
– A significant improvement has been achieved in the timeliness of complaint responses (Well Led, Effective)
– Maternity services have strengthened their approach to receiving and responding to feedback from women, greater engagement with service users is seen as key to the success of this (Safe, Effective)

Many of the projects have now evolved and will become part of additional improvement work in 2017/18. This will be monitored through the Risk and Compliance group which reports to Audit and Risk Committee.

Data Quality
The Trust is in the process of implementing the 'Cerner' Millennium electronic patient record (EPR) system, with a go-live date of May 2017. The Trust is continuing to use this opportunity to review and update its data quality protocols and standard operating procedures.

It has been agreed by the Trust's Information Governance and Records Management Group that the data quality team should concentrate its efforts on assuring future state processes for the EPR and ensuring the quality and integrity of patient data being migrated from the legacy systems into the EPR. This includes

- Cleaning of data to be migrated e.g. maximum tracing and validation of NHS numbers and resolution of duplicate patient registrations
- Ensuring that no patient and no future scheduled patient activity is lost during the data migration process
- Agreeing validation standards for patient data which will be entered directly into the new EPR
- Quality ensuring processes for the electronic harmonisation of patient data between the EPR and other clinical systems holding patient data
- Work with the EPR business change and training teams to incorporate data quality awareness

As the current Patient Administration System (PAS) now has a limited lifespan, no further development will be undertaken unless one of the following criteria can be demonstrated

- A patient safety issue needs to be resolved
- There is a national mandate to be implemented before the EPR go-live
- There is a significant impact on the Trusts financial standing or reputation

NHS Number and general medical practice code validity
The Trust submitted records during 2016/17 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 = 99.9%
Outpatient care = 100%
Accident & Emergency Care = 99.1%

– 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 2016 to December 2016, which are the most recent figures in the Data Quality Dashboard.

Information Governance
The Trust Information Governance Assessment report overall score in March 2016 was 74% and graded as 'satisfactory' with all scores at a level two or three.

A programme of work has been undertaken for the 31st March 2017 submission to promote the continued use of technology within the Trust this includes the electronic patient record. There have been online and face to face awareness raising events and visits to wards and departments across the Trust to interact with staff and ensure that all information governance standards are being adhered to.

We expect to achieve 74% compliance in March 2017.

Clinical Coding Error Rate
Calderdale and Huddersfield Foundation Trust were not subject to the Payment by Results clinical coding audit during 2016/17 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.

The NHS Outcomes Framework 2016/17 sets out high level national outcomes which the NHS should be aiming to improve. The framework provides indicators which have been chosen to measure these outcomes. An overview of the indictors is provided in the table. It is important to note that whilst these indicators must be included in the Quality Accounts the more recent national data available for the reporting period is not always for the most recent financial year. Where this is the case the time period used is noted underneath the indicator description. It is also not always possible to provide the national average and best and worst performers for some indicators due to the way the data is provided.

The information in the table is followed by explanatory narrative for all indicators, ordered by outcome domain.

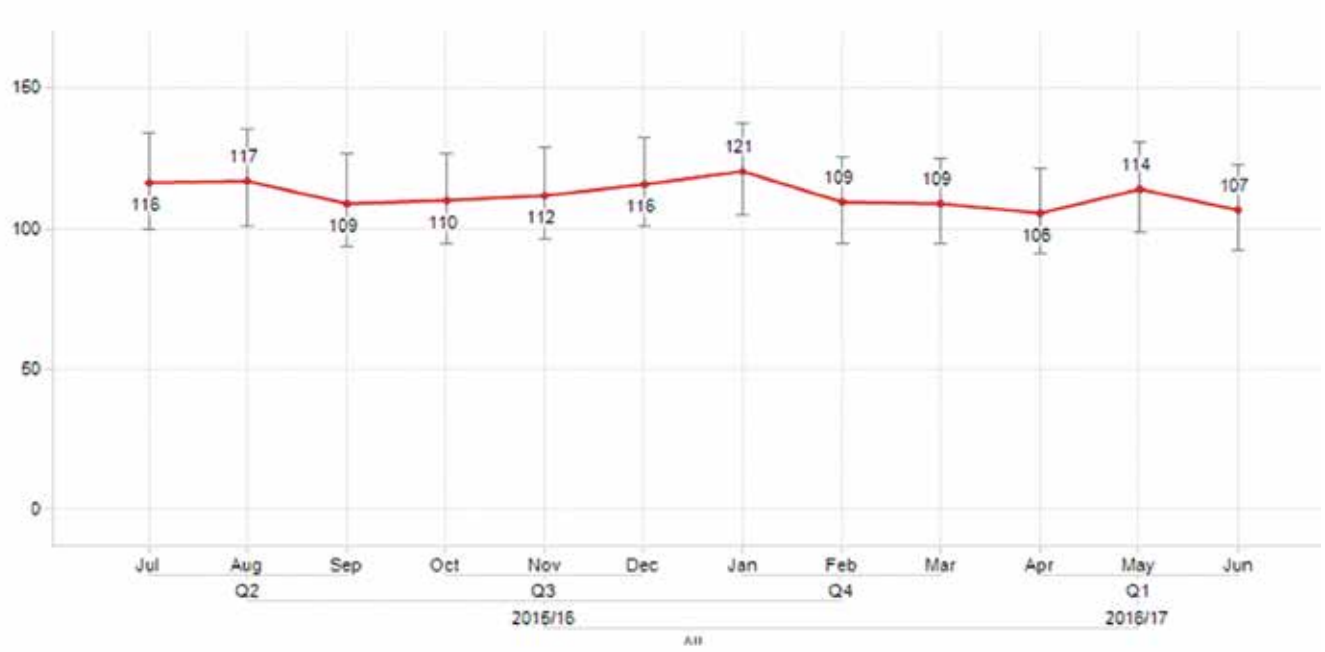
Summary table of performance against mandatory indicators:domain.

Outcome Domain	Indicator	most recent data	National Average	Best	Worse	last report period	last report period	last report period
Preventing people from dying pre-maturely	SHMI Reporting Period: (Oct 15 – Sept 16)					(Jul 15 – Jun16)	(Apr 15 – Mar 16)	(Jan 15 – Dec 16)
	Summary Hospital-Level Mortality Indicator (SHMI) value and banding	SHMI Value = 108 Band 2 = As expected	100	69	116	112 Band 1 = higher than expected	113 Band 1 = higher than expected	114 Band 1 = higher than expected
	The percentage of patient deaths with palliative care coded at either diagnosis or Specialty level for the Trust for the reporting period.	27.9%	29.6%	NA	NA	25.2%	22.2%	18.9%
Helping people recover from episodes of ill health or following injury	18. PROMS; Patient Reported Outcome Measures Reporting Period: (2015/16)					(2014/15)	(2013/14)	(2012/13)
	(i) groin hernia surgery,*	0.07	0.09	N/A	N/A	0.08	0.07	0.07
	(ii) varicose vein surgery,*	0.12	0.10	N/A	N/A	0.12	0.11	0.10
	(iii) hip replacement surgery, and *	0.45	0.44	N/A	N/A	0.45	0.44	0.43
	(iv) knee replacement surgery.*	0.32	0.33	N/A	N/A	0.33	0.34	0.37
	19. Patients readmitted to a hospital within 28 days of being discharged. Reporting Period: Apr16 – Dec17					(2015/16)	(2014/15)	(2013/14)
	(i) 0 to 15; and	11.40%	Not released by NHS Digital 11.95% 10.80%			11.43%	10.64%	10.06%
	(ii) 16 or over.	12.63%				11.26%		
Ensuring that people have a positive experience of care	National Survey Reporting Period: 2015					2014	2013	2012
	20. Responsiveness to the personal needs of patients.	7.1	N/A	N/A	N/A	7.1	6.9	6.9
	Reporting Period: 2016					2015	2014	2013
	21. Staff who would recommend the Trust to their family or friends.	3.72	3.76	4.10	3.30	3.67	3.68	3.57
Treating and caring for people in a safe environment and protecting them from avoidable harm	Reporting Period: Apr16 – Mar 17					2015/16	2014/15	2013/14
	23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	95.11%	N/A	N/A	N/A	95.4%	95.3%	96.2%
	C.difficile Reporting Period: Apr 15 –Mar 16					14/15	13/14	12/13
	24. Rate of C.difficile per 100 000 bed days (2014/15)	10.6	14.9	0	66	11.4	6.2	12
	Patient Safety Incidents - Reporting Period: Oct 15 – Mar 16					Apr 15-Sept 15	Oct 14 - Mar 15	Apr 14 – Sept 14
	(i) Rate of Patient Safety incidents per 1000 Bed Days	40.1	38.58	N/A	N/A	37.5	37.9	36.2
	(ii) % of Above Patient Safety Incidents = Severe/ Death	0.1%	0.2%	N/A	N/A	0.7	0.7%	0.4%

Domain: Preventing people from dying prematurely

The Summary Hospital Mortality Index (SHMI) is a measure of mortality developed by the Department of Health, which compares our actual number of deaths with the predicted number of deaths. Each hospital is placed into a band based upon their SHMI, the Trust is currently in the 'higher than expected' category.

There is a six month time lag in the availability of data for this indicator. The past 12 months performance is reflected below. SHMI cannot be used to directly compare mortality outcomes between trusts and it is inappropriate to rank trusts according to their SHMI.



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

The Trust has undertaken a lot of work to understand what this ratio is telling us about our hospital. As explained by NHS Digital, SHMI is not a measure of quality of care and that a higher/lower than expected number of deaths should not immediately be interpreted as indicating poor/good performance and instead should be viewed as a 'smoke alarm' which requires further investigation.

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

Over the last 12 months the trust has reviewed almost 700 deaths (43% of all deaths) using a process of initial screening by senior doctors and nurses. These reviewers escalate for a second level to provide a more extensive review where quality of care or avoidability issues have been observed. This process is in addition to deaths where concerns have been raised through our established incident process. The purpose of the routine reviews is to have a better understanding of care leading up to a patient's death so we can learn and improve the way we care for our patients including where the death was expected.

A Mortality Surveillance Group, MSG, was set up in May 2016 and is chaired by the Medical Director. The MSG receives reports and agrees further actions. This includes requests for further analysis of certain conditions and has included stroke and pneumonia deaths. In both these cases, the analysis has led to improvement work to reduce deaths in these areas.

We have an established Care of the Acutely Ill Patient (CAIP) programme. The CAIP programme has an overall aim to reduce mortality and is divided into six themes:

1. Investigating causes of mortality and learning from findings
2. Reliability in clinical care

3. Early recognition and treatment of deteriorating patients
4. End of life care
5. Caring for frail patients
6. Clinical coding

The CAIP improvement plan was revised in 2016 and is monitored by the Clinical Outcome Group and reports quarterly to the Quality Committee. Performance is measured in the CAIP dashboard. The work of the CAIP has seen improvements in the level and depth of clinical coding, improvements with recognising deteriorating patients through the implementation of the NerveCentre to electronically collect the national early warning scores (NEWS) and establishment of an active End of Life Steering Group.

A frailty strategy has been developed with a work plan and led by a multi-disciplinary team and community partners with a focus on falls, urinary tract infections and assessment of frailty by district nurses. There continues to be close working with the EPR team to develop clinical care pathways and bundles to assure reliable care.

Domain: Helping people recover from episodes of ill health or following injury

Patient reported outcome measure
A patient reported outcome measure is a series of questions that patients are asked in order to gauge their views on their own health. In the examples of groin hernia surgery, varicose vein surgery, hip replacement surgery and knee replacement surgery, patients are asked to score their health before and after surgery. We are then able to understand whether a patient sees a 'health gain' following surgery.

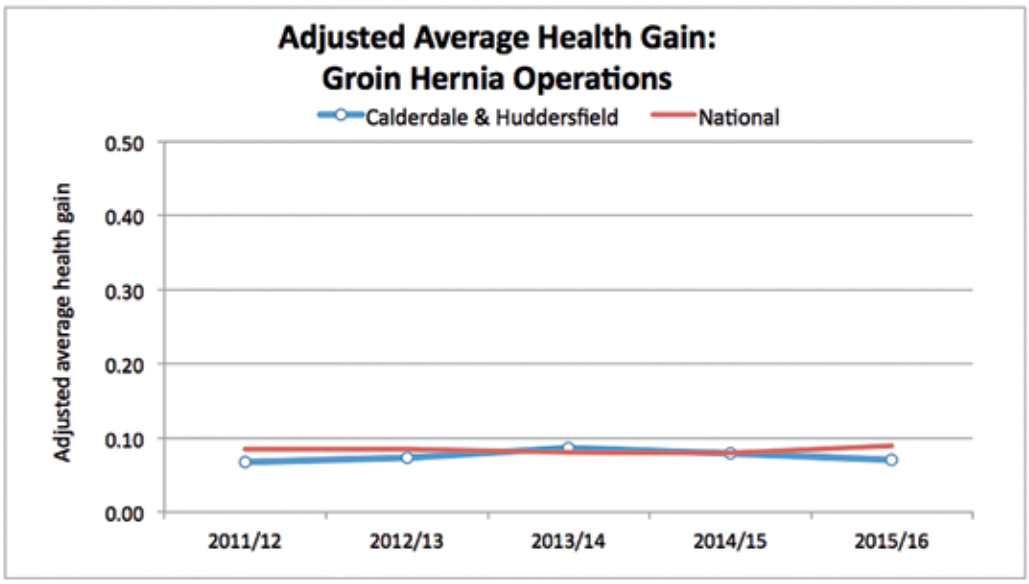
The data provided gives the average difference between the first score (pre-surgery) and the second score (post-surgery) that patients give themselves.

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

Participation rate across all 4 procedures, for CHFT was 73.9%, which was above the national average of 69.8%.

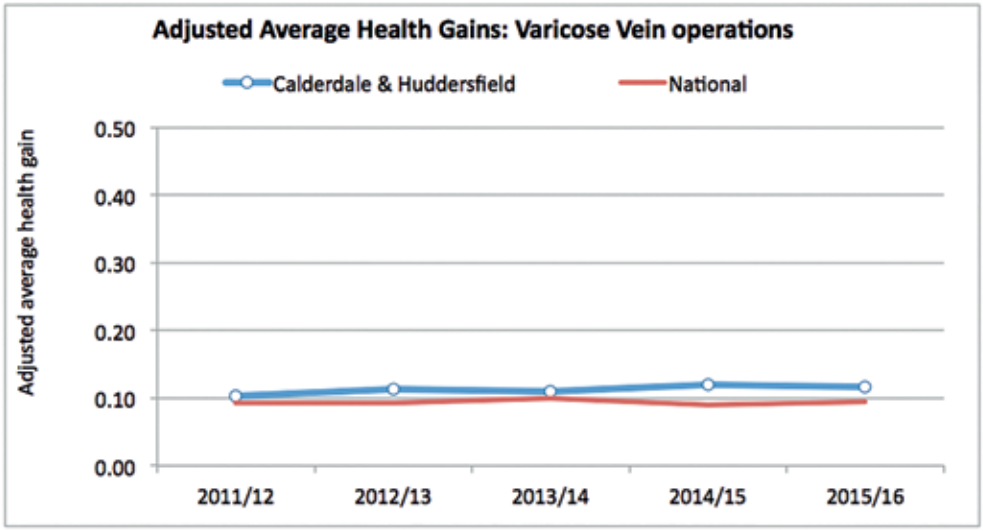
(i) groin hernia surgery,

	2011/12	2012/13	2013/14	2014/15	2015/16
Calderdale & Huddersfield	0.07	0.07	0.09	0.08	0.07
National	0.09	0.09	0.08	0.08	0.09



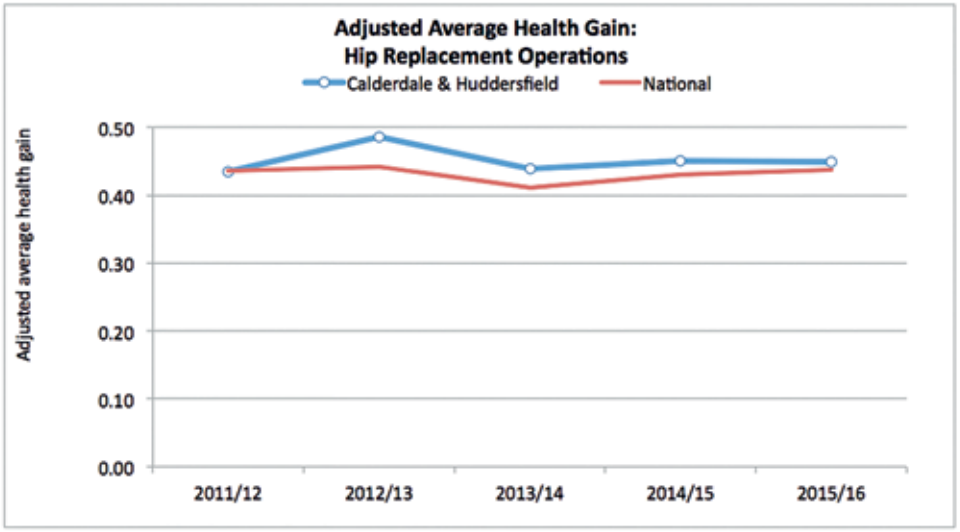
(ii) varicose vein surgery,

	2011/12	2012/13	2013/14	2014/15	2015/16
Calderdale & Huddersfield	0.10	0.11	0.11	0.12	0.12
National	0.09	0.09	0.10	0.09	0.10



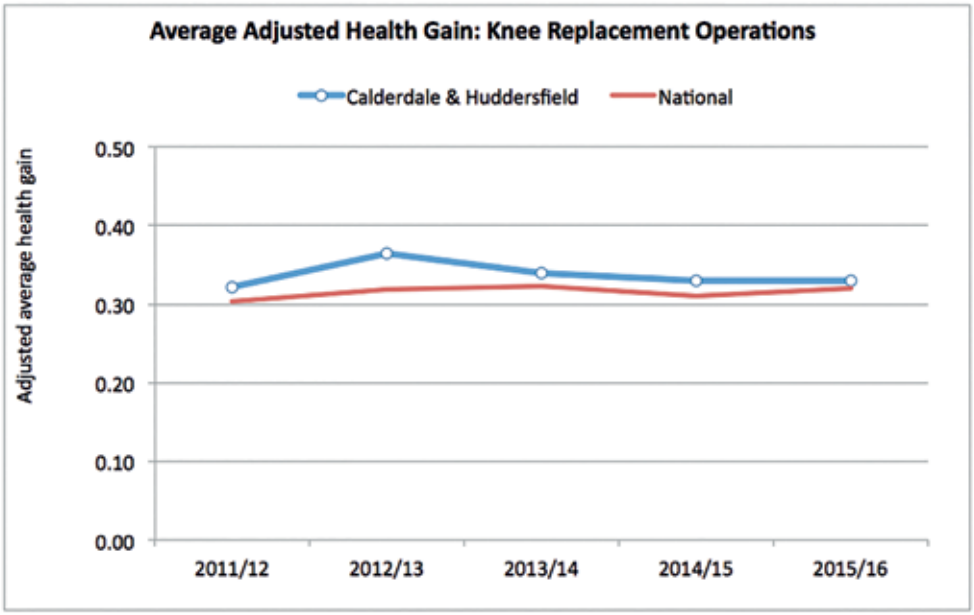
(iii) hip replacement surgery,

	2011/12	2012/13	2013/14	2014/15	2015/16
Calderdale & Huddersfield	0.44	0.49	0.44	0.45	0.45
National	0.44	0.44	0.41	0.43	0.44



(iv) knee replacement surgery.

	2011/12	2012/13	2013/14	2014/15	2015/16
Calderdale & Huddersfield	0.32	0.37	0.34	0.33	0.33
National	0.30	0.32	0.32	0.31	0.32



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

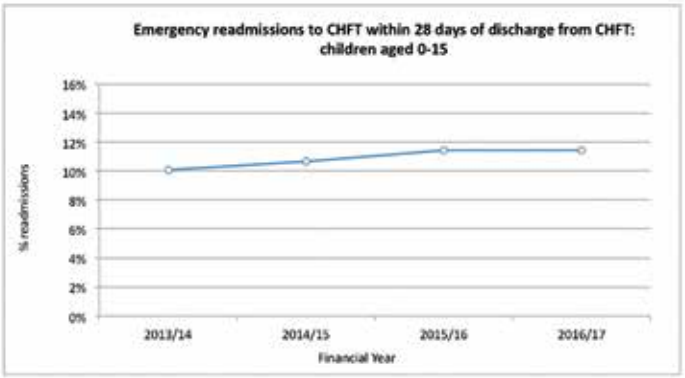
Continuing to ensure this data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice.

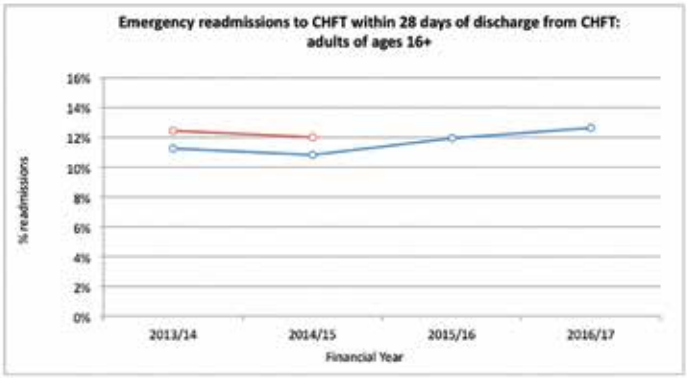
READMISSIONS WITHIN 28 DAYS

The charts show the percentage of patients aged:

1. 0 to 15; and
2. 16 and over;

	2013/14	2014/15	2015/16	2016/17
0-15	10.06%	10.64%	11.43%	11.40%
16+	11.26%	10.80%	11.95%	12.63%





Calderdale and Huddersfield NHS Foundation 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 NHS Digital until a methodological review takes place.
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

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

- Through better planned discharges which will lead to fewer readmissions, see quality priority 2 (page 10)
- Implementation of Safe and Effective Patient Flow Programmes

Responsiveness to the personal needs of patients (Question 20).
The national indicator is a composite of the following questions and calculated as the average of five survey questions from the National Inpatient Survey.

Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs" (based on the 2015 survey).

- *Q33: Were you involved as much as you wanted to be in decisions about your care and treatment?*
- *Q36: Did you find someone on the hospital staff to talk to about your worries and fears?*
- *Q38: Were you given enough privacy when discussing your condition or treatment?*
- *Q61: Did a member of staff tell you about medication side effects to watch for when you went home?*
- *Q67: Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?*

20. Responsiveness to the personal needs of patients.	2012	2013	2014	2015
	7.0	6.9	7.1	7.1

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

The National Inpatient Survey was sent to 1250 patients who had been discharged from inpatient wards at Huddersfield Royal Infirmary (HRI) or Calderdale Royal Hospital (CRH) in July 2015. People were eligible for the survey if they were aged 16 years or older, had spent at least one night in hospital and were not admitted to maternity or psychiatric units. Overall, we had 552 patients who returned completed questionnaires giving a response rate of 44%. This has dropped slightly compared to previous surveys, see the table below:

% of Responses for National Inpatient Survey	2012	2013	2014	2015
	50%	51%	49%	44%

Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve this score and the quality of its services by continuing to use patient feedback to create improvement plans for both the overall Trust and individual areas.

Staff Experience

Staff who would recommend the Trust to their family or friends (Question 21)

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

A total of 850 colleagues were randomly selected in our sample by Picker Institute Europe, our survey co-ordinator. Our Picker response rate was 45% (40.5% in 2015).

Our actual scores remained unchanged from 2015. Our best performance areas are:
- Percentage of staff experiencing discrimination at work in the last 12 months
- Percentage of staff able to contribute towards improvements at work
- Percentage of staff experiencing physical violence from staff in last 12 months
- Staff satisfaction with the quality of work and care they are able to deliver
- Staff confidence and security in reporting unsafe clinical practice

Our worst performance areas are:
- Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- Organisation and management interest in and action on health and wellbeing
- Percentage of staff satisfied with the opportunities for flexible working patterns
- Percentage of staff agreeing that their role makes a difference to patients/service users
- Quality of appraisals

The staff survey score for indicator KF1 with contributing questions:

Question/ Indicator	CHFT 2015	CHFT 2016	National Average
Q21a Care of patients/service user is my organisations top priority	75	77	76
Q21b My organisation acts on concerns raised by patients /service users	68	74	74
Q21c I would recommend my organisation as a place to work	54	59	62
Q21d If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation.	67	68	70
KF1 - Staff recommendation of the Trust as a place to work or receive treatment	3.67	3.72	3.76

Staff recommendation of the Trust as a place to work or receive treatment is 3.72 out of 5.

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

The Trust is shown as average for indicator KF26, percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months and KF21, percentage believing that the Trust provides equal opportunities for career progression/ promotion for the Workforce Race Equality Standard.

3.2. Summary of all Key Findings for Calderdale and Huddersfield NHS Foundation Trust

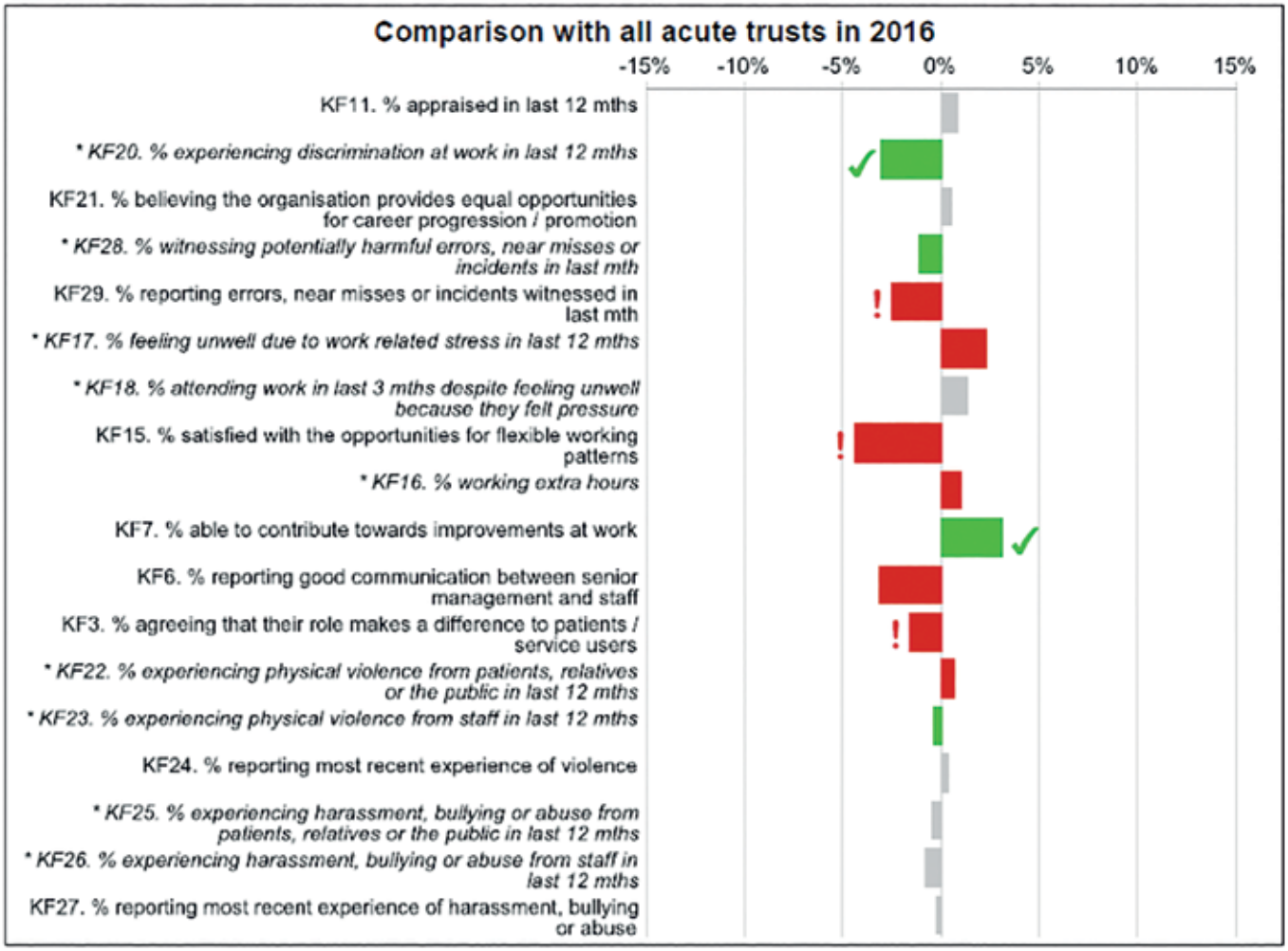
KEY

Green = Positive finding, e.g. better than average. If a ✓ is shown the score is in the best 20% of acute trusts

Red = Negative finding, i.e. worse than average. If a ! is shown the score is in the worst 20% of acute trusts.

Grey = Average.

For most of the Key Finding scores in this table, the higher the score the better. However, there are some scores for which a high score would represent a negative finding. For these scores, which are marked with an asterisk and in *italics*, the lower the score the better.



Workforce Strategy
Calderdale and Huddersfield NHS Foundation Trust has implemented the Workforce Strategy which has at its core four behaviours that the Trust expects to see across the organisation. The Trust continues to work to embed these key values through its Working Together, Get Results programme.

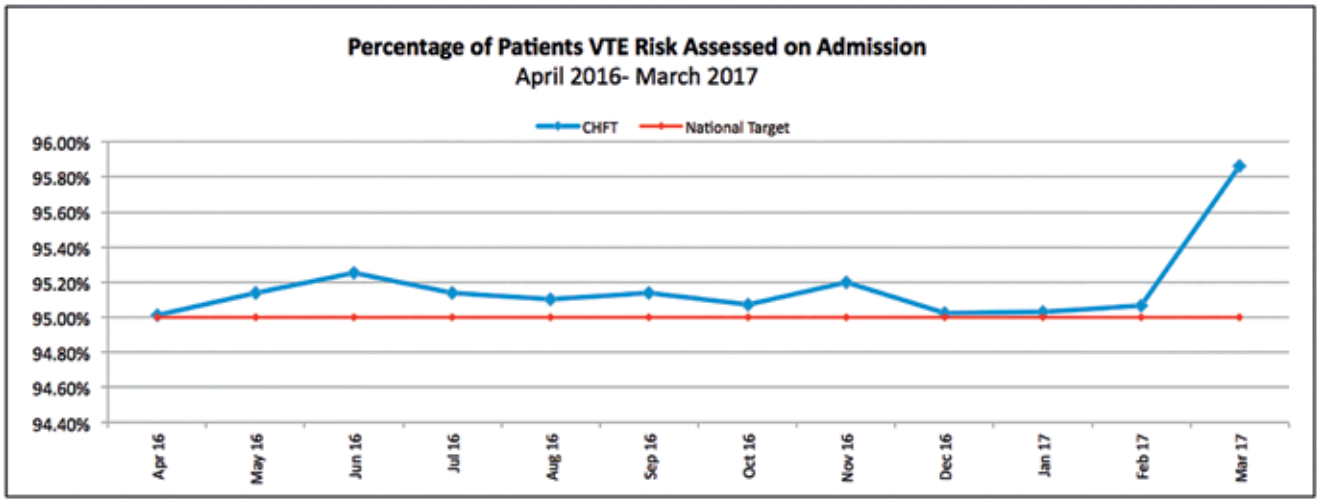
The behaviours are:

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

Domain: Treating and caring for people in a safe environment and protecting them from avoidable harm

Patients admitted to hospitals that were risk assessed for venous thromboembolism.

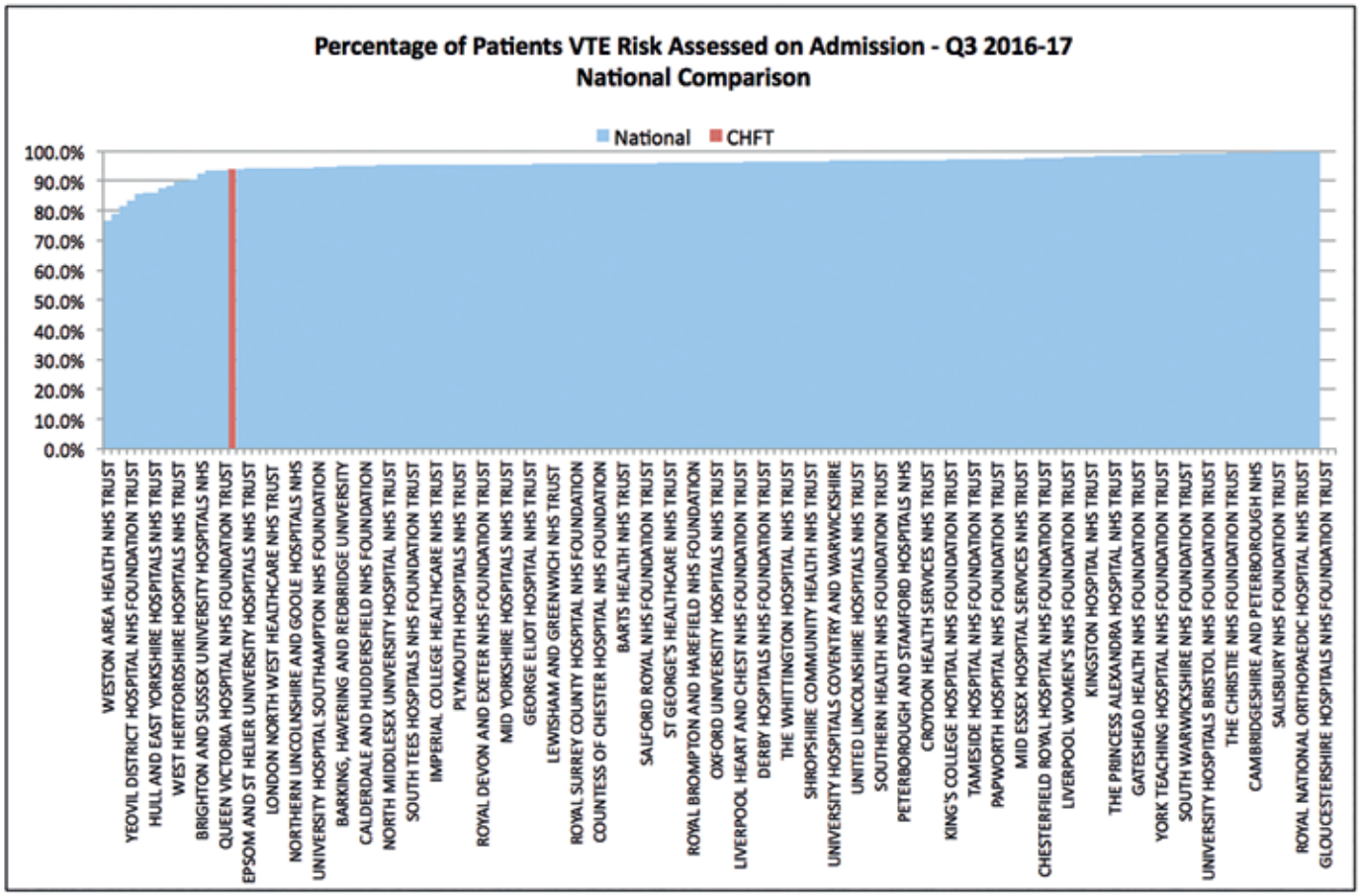
Risk assessing inpatients for venous thromboembolism (VTE) is important in reducing hospital acquired VTE. The chart shows the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from April 2016 to March 2017. The target from December 2012 for VTE risk assessment for all patients admitted was set at 95% and this has been consistently met.



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

Compliance data is currently retrieved manually after the patient has been discharged from hospital.

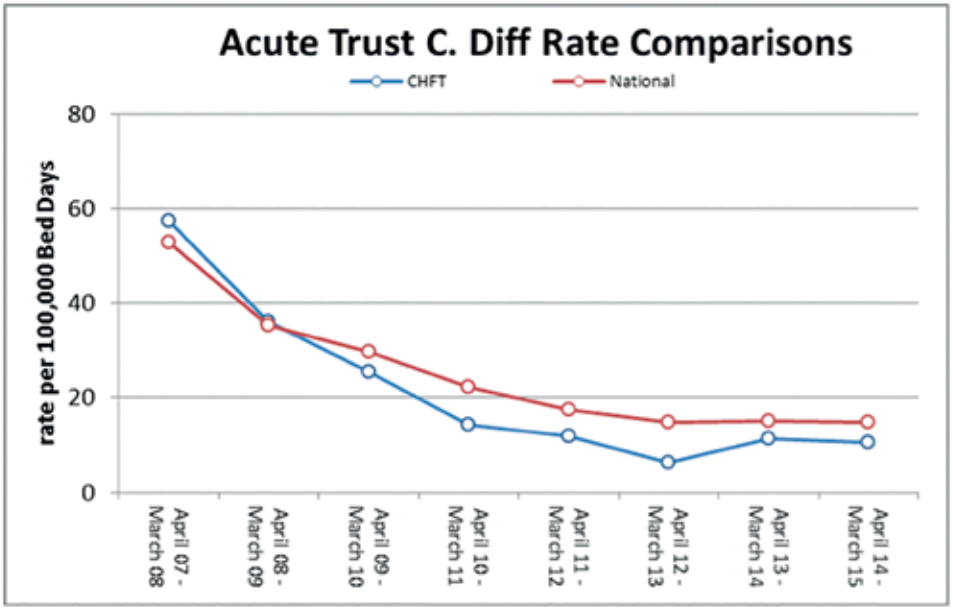
The benchmarking graph shows the Trust to be in the bottom third of Trusts, however issues with data capture make it difficult to evidence performance above the 95% target.



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

- To improve reliability of data and patient care, work is underway to have the VTE assessment incorporated in the new EPR for doctors to complete. This will allow data on compliance with the process to be reviewed live so any issues can be addressed immediately. In addition to this the system will include a prompt the doctors to review the VTE assessment after 24 hours.
- There is a reliable process in place to ensure that when hospital associated VTE's are identified they are investigated for any failings of care and actions taken wherever necessary.

Rate of C.difficile per 100,000 bed days (2016/17)



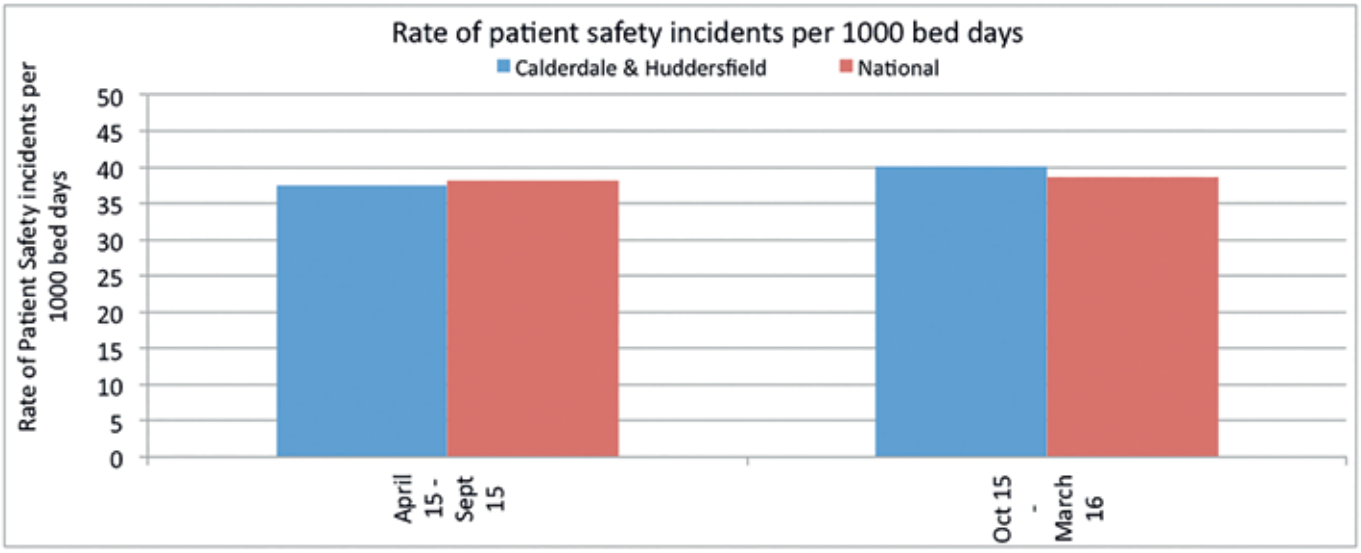
2016/17 has been a challenging year with respect to our absolute numbers of Clostridium difficile infections (CDI), specifically in relation to our performance versus our target. However, we continue to report rates of infection below the national average as indicated below. Of 154 reporting Trusts, Calderdale and Huddersfield NHS Foundation Trust is 42nd in the league table nationally.

At the time of writing, we have exceeded our ceiling of cases of CDI by five cases (ceiling 24, current position 29 cases). All cases are subject to a root cause analysis which is externally supported, and scrutinised, by our commissioners. In the vast majority of cases, we have been unable to identify specific lapses of care that have directly led to the CDI – the quality of the care provided has been found to be good.

However, in six cases, we have been able to identify key areas for improvement. These relate to antimicrobial use prescribing, environmental cleaning and hand hygiene. All root cause analyses conclude with an action plan to ensure that lessons learnt are acted upon, and that learning is disseminated throughout the organisation to try to prevent similar, avoidable cases. Action plan completion is monitored through the Risk and Governance Team.

The Infection Prevention and Control Team support prevention of C. difficile through the delivery of both mandatory training, and bespoke sessions to clinical areas. An annual hand hygiene roadshow is held which has shown good, rising levels of compliance with bare below the elbows and hand hygiene. Additionally we continue to work with clinical teams and microbiology to improve antimicrobial prescribing through the use of antimicrobial stewardship ward rounds, and with Estates and Facilities to maintain, and improve where necessary, standards of cleaning.

(i) Rate of Patient Safety incidents per 1000 Bed Days



The chart above shows the Trust's previous reporting on the National Reporting and Learning System. Calderdale and Huddersfield NHS Foundation Trust consider that this data is as described for the following reason:

It illustrates the improvement with the Trust now reporting above the national average from October 2015 onwards.

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

Serious Incidents
The Trust is committed to improve patient safety by identifying, reporting and investigating serious incidents (SIs), ensuring that actions are taken to reduce incidents reoccurring and that learning is shared across the organisation.

During 2016/17 an Executive Director SI panel was held on a weekly basis to assess potential serious and severe harm incidents that may meet the reporting criteria. Decisions are collectively made with regard to grading of incidents, duty of candour leads and allocation of investigators.

All serious incidents are reported to commissioners. A root cause analysis investigation (RCA) is undertaken for each serious incident and a report and action plan produced which is shared with the patient and / or their relatives. Each report is reviewed at the SI panel which consists of the Medical Director, Chief Nurse and Governance and Risk team to ensure it addresses the root cause of the incident and identifies appropriate actions.

Once approved reports are submitted to the commissioners and the relevant Divisional Patient Safety Quality Board and managers follow up monitoring of the actions arising from the investigation.

A Serious Incident Review Group met six times during the year, chaired by the Chief Executive, with membership including senior clinical divisional colleagues. The group provides assurance that the Trust is managing SIs effectively, identifying themes and seeks assurance that learning from SIs is shared across the organisation. The group reports to the Quality Committee.

The Quality Committee also receives information on new SIs and recommendations and actions being taken to reduce risk.

Learning from Incidents
During 2016/17 the Serious Incident Review Group commissioned work on how the Trust can learn better from all adverse events. Following a survey of staff and focus groups a framework for learning from adverse events has been developed is being implemented.

Themes and trends: The three most frequently reported serious incidents in 2016/17 were:

Incident Type	Number in 2016/17	Comment
Falls with harm	21 incidents	Further detail on work on falls is given in the first section of part 2 of the Quality Account, headed Falls and the implementation of Safety Huddles and in part 3, Falls in Hospital. The falls collaborative action plan has recently been reviewed. Falls risk documentation has been improved and a post falls assessment document has been tested, which looks at immediate risks at the scene of an incident and is being reviewed. Ongoing work is supported by the Improvement Academy.
Pressure ulcers (hospital acquired)	11 incidents	There has been a revised pressure ulcer panel process and clear focus on undertaking root cause analysis on avoidable hospital acquired pressure ulcers to identify any omissions in care.
Treatment delays	9 incidents	This theme includes the locally agreed cancer pathway breaches of treatment over 104 days where harm has occurred. Such incidents are reported as a red incident so that we can identify areas for improvement. Work is underway to identify learning and a combined action plan will be developed once all investigations are complete.

Two of the top three types of serious incidents, falls with harm and pressure ulcers are consistent with the top three types of serious incidents across West Yorkshire (source: NHS England) in 2016/17 based on 12 month data to December 2016. Our investigations into these incidents enable us to identify and undertake preventative work to improve patient safety.

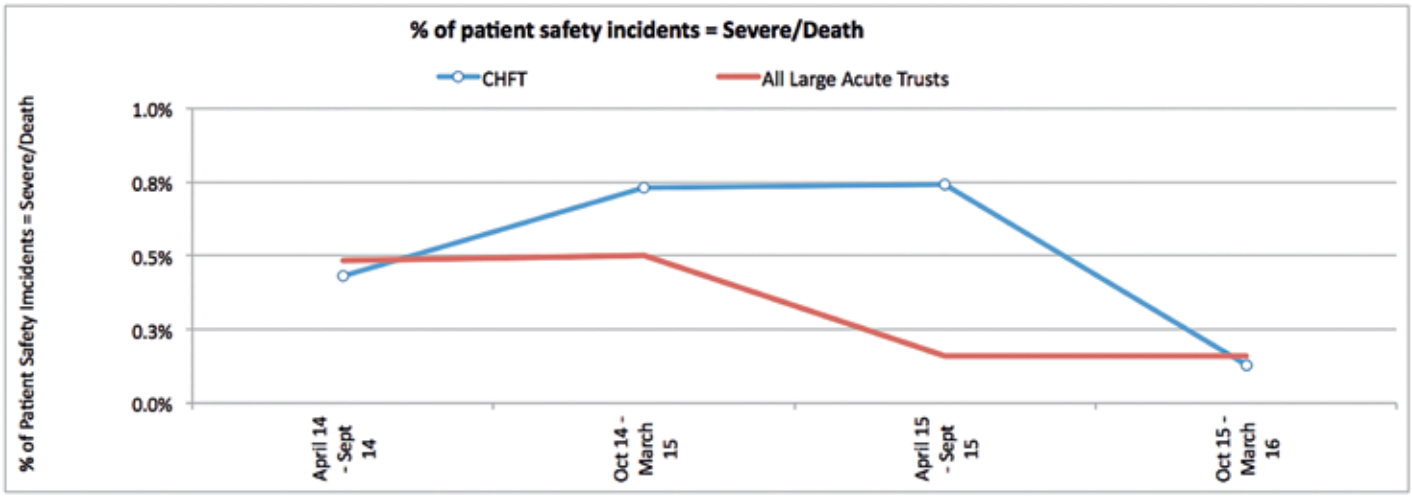
Never Events
A never event is a specific serious incident that NHS England has determined is avoidable and should not happen if national safety guidelines are followed. There are 14 types of never event listed by NHS England.

Over 2016/17 we have reported two never events:
- 1 mis-placed naso-gastric tube
- 1 retained swab following a surgical procedure.

The two never events were reviewed by the Medical Director, Director of Nursing, Divisional Directors, clinical teams and commissioners. The implementation of the actions following investigation is monitored via the relevant Divisional Patient Safety Quality Board

(ii) % of Patient Safety Incidents graded as Severe/Death

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



The above table shows that the Trusts reporting of patient safety incidents is now in line with other large acute trusts. This is attributable to work reviewing pressure ulcer incidents and ensuring that only hospital acquired avoidable pressure ulcers are reported, compared with previous approach of viewing all category 3 and 4 pressure ulcers as severe harm (see Table 8 below). Pressure ulcers remain one of our top 3 types of serious incidents.

Incidents by severity:
The total number of patient safety incidents reported has decreased by 6% from the previous year, 2015/16, which had shown a significant increase from 2014/15. National benchmarking activity for the first six months of 2016 shows that the Trust is in the middle 50% of reports comparted to our peers (at the upper end of the benchmarking data). The level of incident reporting is reflective of a positive incident reporting culture and was highlighted favourably during our CQC inspection in March 2016.

There has been an increase in incidents rated as orange and red due to increased scrutiny of patient harm incidents and potential for learning and improving patient safety, for example all potentially avoidable patient falls with harm are now investigated as a serious incident, increasing the opportunity for learning.

Patient safety incidents make up 84% of all reported incidents.

Table 8: Patient Incidents by Severity

CHFT Incidents	2014/15	2015/16	2016/17	movement
Green	4973	6467	6337	↓ -2%
Yellow	1651	1955	1478	↓ -24.4%
Orange	101	130	165	↑2.69%
Red	136	44	74	↑ 6.8%
Totals	6861	8596	8054	↓ -6.3%

Green / Yellow Incidents (No / low harm)
There has been a decrease in the reporting of green, no harm, incidents and a decrease in the number of yellow incidents reported compared to 2015/16.

Overall there has been a 7% reduction in reporting of green and yellow incidents compared to 2015/16, which may be due to an increase in the quality and appropriateness of reporting. Part way through 2015/16 work took place to ensure more accurate grading of incidents which may be why green and yellow incidents were higher in that year.

Work will continue in 2017/18 to encourage appropriate reporting of incidents and near misses. Work will also take place to analyse patient safety incident data to understand which type of incidents have seen reduced reporting and whether this is due to improved patient safety from having implemented learning from incidents (representing an improvement and therefore an appropriate reduction in incident levels) or a true reduction in the reporting of incidents by staff.

Orange incidents (moderate harm)
Throughout the Trust, weekly incident panels for those incidents that have caused moderate harm have continued to take place at a divisional level, ensuring a robust process for assessing incidents, reviewing completed investigation reports and ensuring effective communication with those affected by the incident, known as duty of candour is completed in a timely manner. The increase of orange incidents shows that more divisional investigations are taking place to improve patient safety and support staff in learning from incidents.

Red incidents (serious incidents)
In 2016/17 - 74 incidents were severity rated as "red – serious" and reported to the Clinical Commissioning Group as per the requirements of the National Serious Incident Framework. The increase in red incidents reflects decisions to report all avoidable falls with harm and cancer pathway breaches over 104 days as red incidents, so that we can identify learning and make improvements. There has also been changes in the reporting of pressure ulcers with serious incidents reported based on severity of harm and avoidability rather than previous systems of category of pressure ulcer.

The increase in the reporting of red incidents also supports the fact that more in-depth root cause analysis investigations are taking place within the Trust, thus emphasising the Trust's commitment to learning to improve standards of care and treatment overall.

Duty of Candour
All Trusts are required to comply with the statutory duty of candour after becoming aware of an incident which has caused harm classed as moderate, severe or death on the National Reporting and Learning Systems (NRLS). Notifiable safety incidents also include those that have caused prolonged psychological harm.

During 2016/17 a significant amount of work has taken place to ensure that patients / families affected by an incident that has caused harm (i.e. those categorised as orange or red incidents) are informed of the incident promptly. This has included introducing a system to highlight any outstanding notifications so that these can be undertaken in a timely way, improving recording on our incident reporting system, and support for staff in undertaking the duty of candour. This has led to increased confidence in staff in talking to patients and relatives where harm has been caused.

We monitor performance on duty of candour and information is reported monthly to the Trust Board.

Once a report is completed patients and relatives are routinely offered a meeting with staff to discuss the report, unless they have previously indicated that they do not wish to meet.

The duty of candour policy and the way that duty of candour is delivered is being amended through discussion with our staff and our commissioners. This includes improving the way in which our staff correspond and communicate with patients and relatives in line with their feedback. This has included ensuring letters to families are clearer and personal.

Part 3: Performance on selected quality indicators

This section provides an overview of care offered by the Trust based on its performance in 2016/17 against a number of regularly monitored quality indicators. These are selected by the Trust Board in consultation with stakeholders and reviewed regularly.

The indicators are as follows:

Domains	Indicator
Patient Safety	Mortality Rates (HSMR and SHMI)
	Falls in Hospital
	Healthcare Associated Infections
Clinical Effectiveness	Cancer Waiting Times
	Stroke
	Safe and Effective Care (previously LoS Medicine)
Patient Experience	End of Life care
	Patient Experience Inc Friends and Family Test
	Complaints
Staff Experience	National Survey
	Friends and Family Test

Hospital Standardised Mortality Rate (HSMR)

Through understanding our hospital mortality the Trust is able to both gain assurance and learning regarding current care processes and further identify any areas requiring improvements.

There are two main standardised measures. These ratios examine the number of patients who die, either during or, following hospitalisation at the Trust by looking at the expected number of cases in an average English hospital, given the characteristics of the patients treated there.

1. The SHMI calculated by NHS Digital looks at patients who had died either in hospital or within 30 days of discharge.

2. The HSMR is a long standing national measure which only looks at those patients who die during their hospital stay.

See **Part 2** for a look into our SHMI performance and work on the Mortality Case Note Review programme. (page 124).

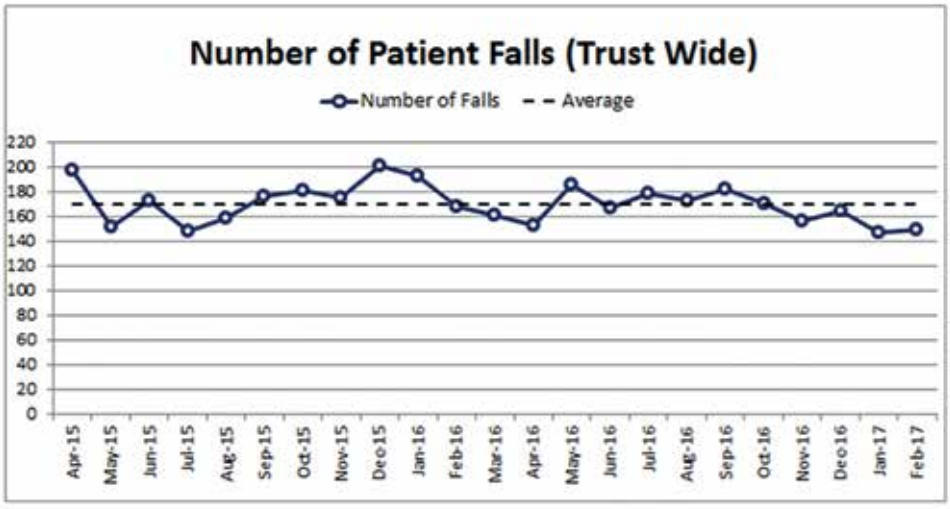
Falls in Hospital

Falls in hospitals are the most common patient safety incidents reported in hospitals in England. Falls not only impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality, they are estimated to cost the NHS more than £ 2.3 billion per year.

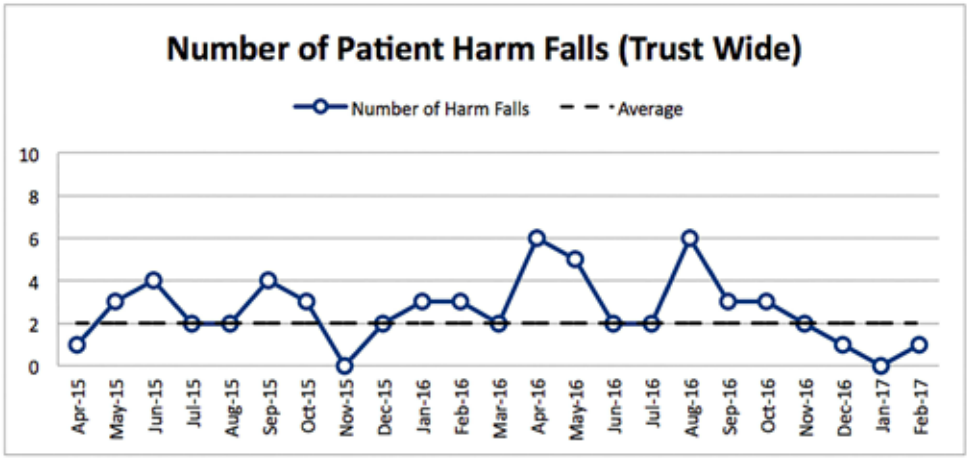
In response to the actions that were agreed at the CHFT Harm Summit in 2015/16, a lead for Falls Reduction was appointed to work with ward areas and improve multidisciplinary working with regard to the assessment and management of patients at risk of falls,

Throughout 2016/17 the work of the falls collaborative has been focussed on the introduction of safety huddles into medical wards areas and linking in with the Improvement Academy and their expertise. This has been a significant piece of work and has complemented a number of other interventions such as reviews of footwear and equipment and embedding bedside handover.

The benefits of these interventions are becoming evident at the end of 2016/17 and improvements are expected to continue.



The chart shows the number of falls patients have had whilst in hospital, on average this was 171 per month. The last four months have shown a positive downward trend. This is more evident when looking at those falls which result in harm, see chart below.



Improvements for 2017/18
The Trust will be once again participating in the National Falls and Fragility Audit of inpatient falls in summer 2017. This gives the Trust an opportunity to explore its processes in comparisons to other Trust in the country.

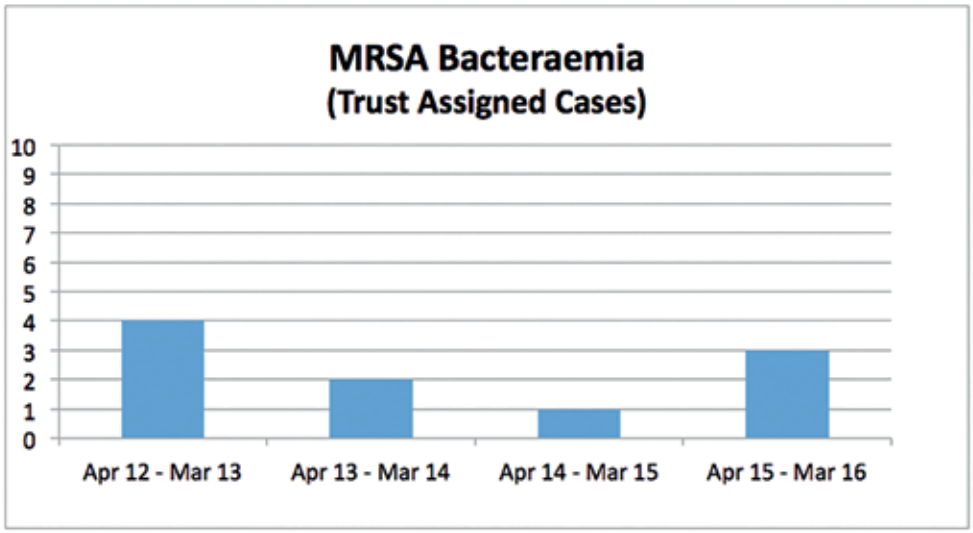
Safety huddles will be supported and strengthen so that they can be maintained and spread out to additional clinical areas.

Healthcare associated infections (HCAIs)

The Trust monitors and reports infections caused by a number of different organisms or sites of infection. These include:

- Methicillin Resistant *Staphylococcus aureus* (MRSA) bloodstream infections
- Methicillin Sensitive *Staphylococcus aureus* (MSSA) bloodstream infections
- *Clostridium difficile* infections (discussed elsewhere)
- *Escherichia* coli bloodstream infections
- Central venous catheter infections
- Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE)

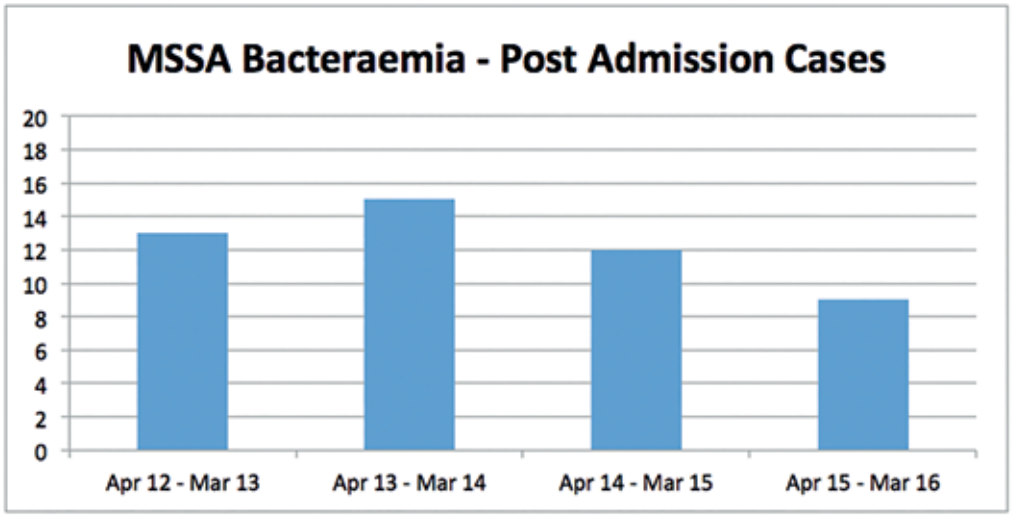
MRSA (Methicillin resistant Staphylococcus aureus) Bacteraemia:



MRSA bacteraemia remains a rare event in Calderdale & Huddersfield NHS Foundation Trust. Two bacteraemias have been reported since April 2016. Both have been subject to Post Infection Review as per national process. Learning has been incorporated in the Trust Infection Prevention and Control Action Plan.

MSSA (Methicillin sensitive Staphylococcus aureus) bacteraemia:

MSSA bacteraemia is not subject to targets in contrast to MRSA bacteraemia. However, mandatory reporting of MSSA bacteraemia is required. In the year to date 12 cases have been reported. These are not subject to a formal post infection review, but are subject to post infection case note review to identify areas of learning that can be disseminated through the Trust. Limited MSSA screening is in place for a select group of patients including patients with central venous catheters.



E.coli bacteraemias:
There are currently no national reduction targets for E. coli bacteraemia, although these are expected to be introduced this year (April 2017). A review of cases indicates the majority of these are sporadic, although a small number are associated with the use of urinary catheters. Measures to tackle E. coli bacteraemia will be incorporated into the Trust action plan for the year ahead.

Central Venous Catheter Infections:
The Trust continues to report low levels of central venous catheter infections. For the 12 month period ending in February 2017, we reported a cumulative infection rate per 1000 CVC days of 0.48. This is well below our internal target of 1.0 per 1000.

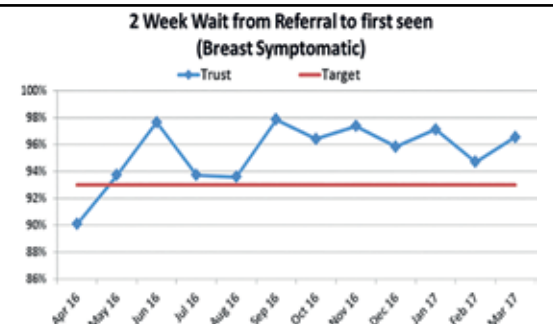
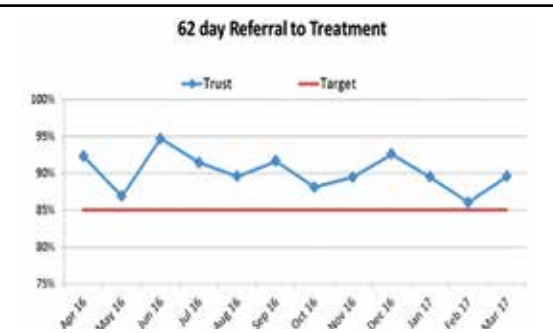
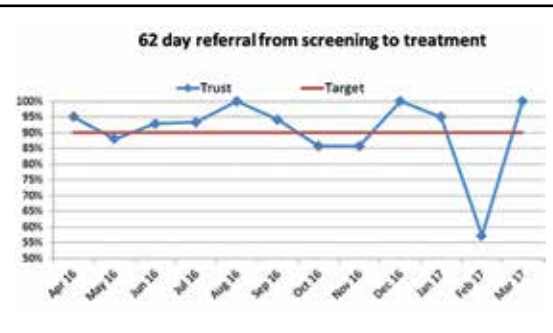
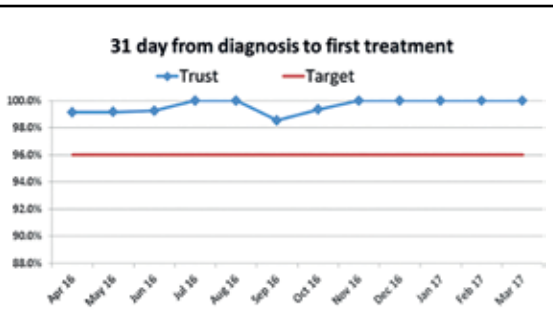
Colonisations/infections with Carbapenemase producing Enterobacteriaceae (CPE):
In line with national guidance from Public Health England, all overnight admissions to the Trust are screened for risk factors for colonisation/infection with CPE. All patients in whom a risk for colonisation or infection is identified are offered microbiological screening. Over the past three years, eight patients have been identified who are colonised with CPE. The Infection Prevention and Control Team support clinical areas with enhanced infection control precautions when these patients are identified.

Key Priority Areas for the Infection Prevention and Control Team:
In addition to working to prevent healthcare associated infections as detailed above, the Infection Prevention and Control Team work to support improvements:

- Hand hygiene
- Appropriate use of invasive devices
- Aseptic Non-Touch Technique (ANTT)
- Cleaning standards
- Water and air quality
- Refurbishment of the hospital estate
- Training and education
- Audits and surveillance

Cancer Waiting Times

Delivery of the National Cancer Targets is a key part of effective cancer care and the Trust's performance around these targets is a significant indicator of the quality of cancer services delivery. The Trust continues to consistently achieve the cancer waiting times standards.

	The performance required for this target is 93% and this has been exceeded for the whole of the year.
	The performance required for this target is 93% and this has been exceeded in all months, accept April 16. This was due to patient choice.
	The performance required for this target is 85%. Performance has been above the required 85% for all of the year.
	The performance required for this target is 90% and the main issue has been bowel screening that has not achieved the target due to a variety of reasons, e.g. patient holiday's inability to place on surgical lists. CHFT do hold all the breaches for us and Mid Yorkshire Trust.
	The performance required for this target is 90% and the main issue has been bowel screening that has not achieved the target due to a variety of reasons, e.g. patient holiday's inability to place on surgical lists. CHFT do hold all the breaches for us and Mid Yorkshire Trust.

Alongside the national standards the Trust is looking to report on regional targets to ensure patients are transferred to specialist hospitals in a timely fashion. This will aim to:

- See Fast Track patients within 7 days

At present YTD 46.8% of patients are being seen within 7 days of referral which compared to the 30% we were achieving in April 2014 is a slight improvement. However it is felt to ensure we meet the other targets this should be made a priority by all tumour sites.

- Carry out any Inter Provider Transfers (IPT) by day 38

The Trust has issues meeting the target of referring 85% of patients to tertiary centres by day 38 of their pathway. Year to date the Trust has sent 44% of the patients by this date. With the imminent changes in the inter provider transfers IPT arrangements if nothing changes this could mean that the Trust starts to fail the 62 day cancer target. There is focussed work on this in the divisions, however progress needs to increase.

Improvement Plans 2017/18
A further review of all tumour sites has taken place to address how the teams can operate differently to meet the 38 day referral to a tertiary centre. An action plan has been put in place by each division as to how they are going to rectify the poor performance. However these need to be monitored to see if they are making a difference to pathways and outcomes.

In line with the 96 recommendations from the "Achieving World Class Cancer outcomes - A Cancer Strategy 2015-2020", the cancer teams alongside commissioners and patients will be work to achieve these. The Trust will be held to account by the commissioners.

A self-assessment for cancer indicators for each tumour site for the Quality Surveillance Team (QST) programme for 2016/17 has been completed and was presented at WEB. The CCG will consider the outcomes of these and can ask for an external visit if they so wish. The QST 2017/18 starts again in April, action plans are completed for each tumour site and should be monitored through the divisions.

Cancer Site Specific and Specialist Palliative Care teams update:
The Trust employs a number of specialist staff in roles to support the delivery of cancer care, and end of life care in both cancer and non-cancer patients.

Specialist nurse roles have evolved due to the changing needs of patients these include a much younger population, changes in treatment choices, more intensive and complex treatments. This alongside an increase in newly diagnosed cancers every year as well as people 'surviving' their cancer and treatment, but living with the side effects of that treatment have meant significant changes for the roles. Living with the consequences of successful cancer treatment is one of the great challenges of modern life.

To meet the changing landscape of cancer treatment and a patient's needs, specialist nurses (working closely with the designated named cancer site specific consultant) have and are developing nurse led clinics: assessing appropriate new cancer fast track patients, undertaking biopsies and ordering investigations, breaking the news of a new cancer to patients as well relevant cancer follow up (appropriate to the training level and competencies of the Specialist Nurse.). A crucial part of Specialist Nurses role is also in the assessment and interventions/care of patients during the patient's treatment, recovery and living with the consequences of the treatment.

The advanced roles that specialist nurses are undertaking in the patient's pathway means that there are changes in professional roles and service provision for patients. As well as piloting nurse consultant posts in cancer teams and how they help improve the patients experience and pathway to treatment, new roles are being considered. One such is the 'Cancer Care Co-ordinators'.

These are non-registered roles, but provide support to patients and co-ordinate all the other referrals to services. They include traditional non specialist parts of Cancer Nurse Specialist (CNS) roles. Cancer Care Co-ordinator posts are a valuable resource in the patient's management for low level specialist intervention once training and experience has been gained. They are a first port of call for patient's questions and queries, emails and phone calls. Baseline assessments and continuity for patients having access to the service can be through these posts.

Throughout 2017 CHFT cancer teams will be working in line with the recommendations from the World Class Cancer Outcomes Strategy 2015-2020 and the National Cancer Patient Experience Survey, we will deliver the living with and beyond cancer agenda, offering health needs assessments at strategic point in the patients pathways, care plans with long term side effects and how to access specialist services at a time when patients need them as well has health and well-being events being offered.

Stroke

Strokes affect between 174 and 216 people per 100,000 population in the UK each year and account for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years. By focusing on improvement in stroke care, patient outcomes can be vastly improved.

The Trust has the following aims to strengthen and improve stroke services:

– Patients are admitted to a stroke bed within 4 hours

– Patients spend 90% of their Hospital Stay on the Stroke Unit

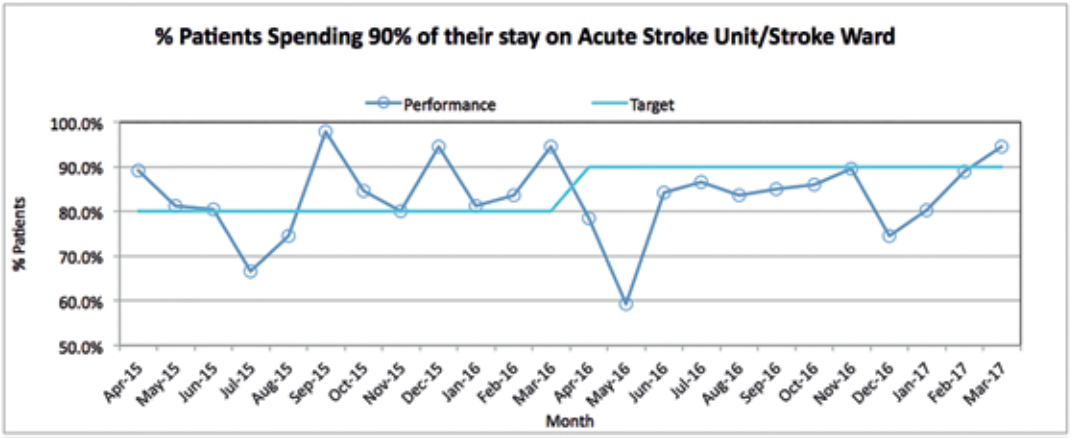
Improvements in 2016/17:

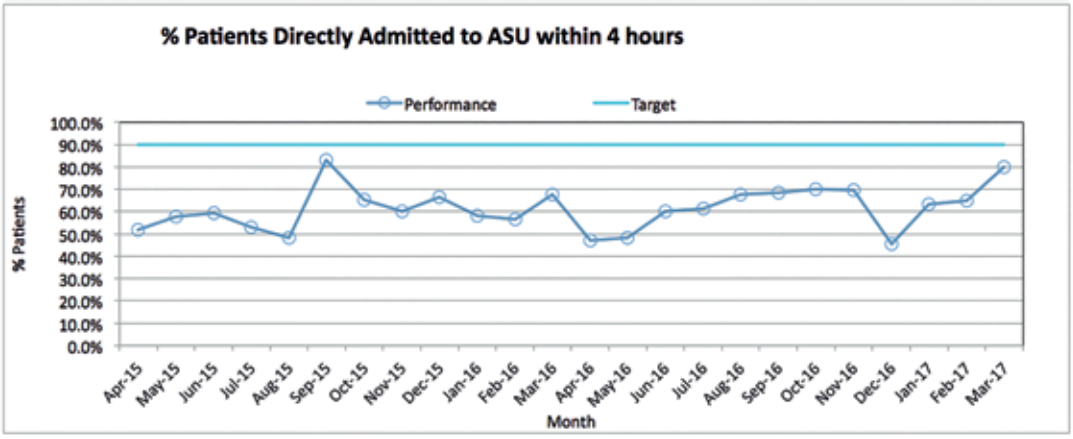
At the monthly Clinical Governance meeting the whole multi-disciplinary team review all the targets. The consultants complete a monthly review of all patients that have died and review how treatment could have changed, if at all possible. The Thrombolysis nurses complete a monthly audit on all patients that were or possibly could have been thrombolysed again stimulating conversation for change and how the team could improve.

A pilot has been held on one of the rehabilitation wards, with positive outcomes around length of stay, team work and improvements in family involvement. To implement this there is a need to change working patterns for doctors, therapists, nurses and social services. The team have been lucky enough to secure a new consultant who will hopefully start in the summer of 2017.

The clinical lead has also written a proposal of how patients can be assessed from immediate presentation to the process through the wards to the patient's final destination. This is being presented to the medical division for their possible support.

The changes will affect the majority of the targets the team are reviewed against in the SSNAP audits.





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. A pilot was carried out from September 2016 until end of March 2017 with good results that are going to be presented to the medical division for support and possible implementation. Unfortunately in December the Acute Stroke Unit had an outbreak of viral gastroenteritis and the service had to be provided on one of the rehabilitation wards.

On the 8th and 9th of December the stroke service underwent an independent service review, led by the Royal College of Physicians which was very positive. The initial letter has been received by the Medical Director but the Trust is awaiting the full report. From the initial letter an action plan has been put in place and this is being monitored, via the directorate.

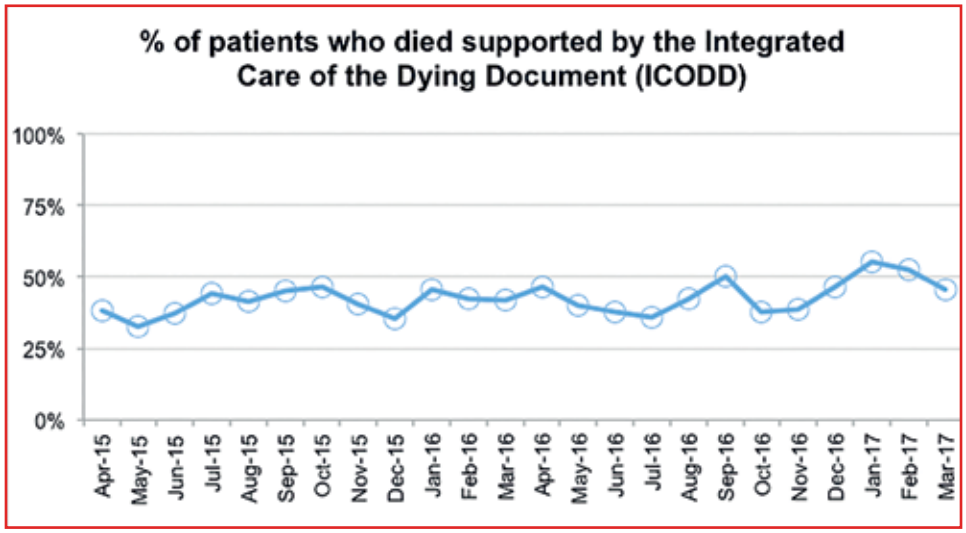
Plans for 2017/18
The team are working closely to improve the services, from reviewing how consultants, physiotherapists, occupational therapists, speech and language therapists, dietetics, social services and the whole team work to improve the quality of the service. This will help with the reduction in length of stay.

Safe and Effective Care (previously Length of Stay in Medicine)
In previous years the Trust has had a focus on monitoring length of stay in medical services, as planned in 2016/17. The Safe and Effective Patient Flow Programmes continued to focus on how best to maximise flow through the organisation. This area has been chosen as a priority for 2017/18 by our membership, see page 5 for measures of success.

End of Life Care
Improving end of life care remains a priority area for the Trust and it continues to work to ensure that when patients die in hospital, and their death is expected, that they receive appropriate end of life care.

End of life care can be complex because of the special needs of many at the end of life and because of the need to co-ordinate and integrate a wide range of services across different sectors. However the rewards for getting it right are huge. Personalised, integrated care at the end of life can transform that experience for the individual, their family, and the staff caring for them.

Key achievements in 2016/17
Since the introduction of a dedicated end of life care plan (the ICODD), there has been a steady increase in the number of patients who die supported by this, to over 50%. This care plan supports staff to deliver high quality care.



The ICODD has been reviewed and amended to ensure that it remains a robust document. These amendments included enhanced clinical guidance on the use of medications at the end of life, and incorporation of guidance relating to the Deprivation of Liberty Safeguards (DoLS) legislation. An authorisation form for car parking for relatives has been added as an appendix and is now completed by ward staff to ensure all families are able to receive free car parking in a timely manner.

Syringe drivers are now managed centrally by the training lead for End of Life care and maintained by the equipment store.

This enables ease of access by all wards to the syringe drivers when they are needed

The Trust Specialist Palliative Care Team (SPCT) has continued to deliver 'in-reach' activity to medical and nursing staff within oncology, gastroenterology and stroke teams. Patients are discussed at 'board rounds' and have expert advice given on symptoms, goals of care, and the suitability of initiation of advance care planning.

The Trust SPCT has also been active all year in delivering a range of educational events to staff working within the Trust. Education is delivered to a variety of professional groups, and this year has seen the delivery of the third successful training day for 38 doctors working across the Yorkshire Deanery. Targeted education to nurses on the Verification of Expected Death (VOED) should greatly reduce the delay and distress caused to families who currently are required to wait for medical staff to verify death, in hospital and in community. The Trust SPCT provides educational sessions on the Preceptorship and Apprentice training programmes and ad hoc ward based training as required.

The End of Life Care (EOLC) Strategy has been developed so that there is now a clear reporting framework. This has been distributed to key staff members and agreed at the Trust Quality Committee. The three key recommendations from the strategy are:

- Priority 1 – Identification of people in the last 12 months of life and high communication with them
- Priority 2 – Coordinated, timely and equitable access to good care
- Priority 3 – Good care in the last days and hours of life.

It is crucial for all 3 priorities to be underpinned by education and training to ensure successful implementation.

The End of Life Care Scoping Facilitator was appointed in June 2016, funded for 12 months by Health Education Yorkshire and the Humber. The post holder's remit was to look at end of life care in the Trust, looking at areas of excellence and where we had gaps to see where our focus needs to lie.

A recent CQC review identified areas of good practice, scoring 'Good' in all five categories. They also commented on areas for improvement and an action plan was developed that focused on addressing the issues raised. These actions are now embedded within the organization and have been signed off by the Trust.

Proposed improvements for 2017/18

An engagement day is planned in early April 2017 with almost 70 staff from primary and secondary care and representatives from external agencies scheduled to attend. The aim from this event is to develop 5 working groups which produce a plan to focus on improving the three priorities from the strategy, education and training and -9 months to 19 years.

We have recently appointed 2 new Advanced Nurse Practitioners and Prescribers to work in the Medical Assessment Unit and the Emergency Department at Huddersfield Royal Infirmary as a two year project funded by Macmillan. The nurses will work with clinicians to make decisions about ceilings of care for patients at the end of their life. The project will commence in early autumn 2017 and will improve the quality of care for patients who are at the end of their life and will provide a seven day service.

The Trust is keen to start to progress the delivery of the EOLC Strategy with our partners. It is envisaged that this work will take place through the five working groups set up following the engagement evet in April 2017.
The reconvened EOLC steering group now meets regularly, and with input from partner organisations, and will address service developments, gaps in delivery, quality issues and other relevant areas.

The Trust public website is being updated and will include information on end of life care.

Patient Experience

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

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

It is important when we measure patient experience, that patients are also given the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family Test (FFT) which is now well established across all inpatient and day case areas, as well as in the A&E and outpatient departments, maternity services and across community services.

Friends and Family Test
The FFT question asks *"How likely are you to recommend our ward / department to friends & family if they needed similar care or treatment?"* ***Performance is monitored internally against the national performance baselines during July – September 2016.***

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

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

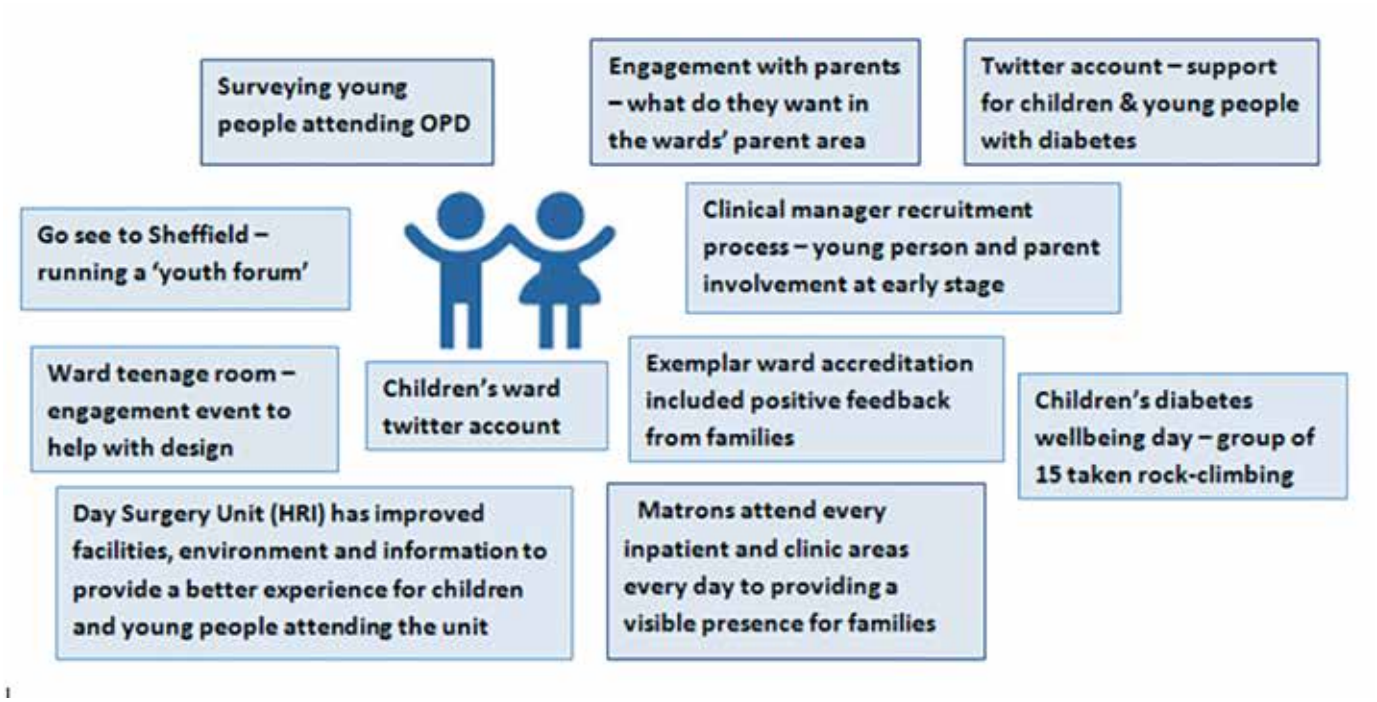
2016/7 % response rate

	2016/17 (11 month data)
Inpatient	34.1%
A&E	13.1%
Maternity	42.4%
Community	11.6%
Outpatients	12.1%

Local Quality Improvement Projects
This year four projects were identified as priorities for quality improvement. Each of these has seen progress over the year and utilised opportunities for service user engagement at various stages.

1.1 Children's voice
Colleagues working with children and young people were keen to create more innovative ways of involving children and young people in their healthcare and also in how services are designed and delivered.

Methods have been used previously, e.g. young people included on recruitment panels, the 15 step challenge; however these tended to be one off initiatives. The aim of this approach was to establish a more robust arrangement, enabling more sustainable activities to be put in place.

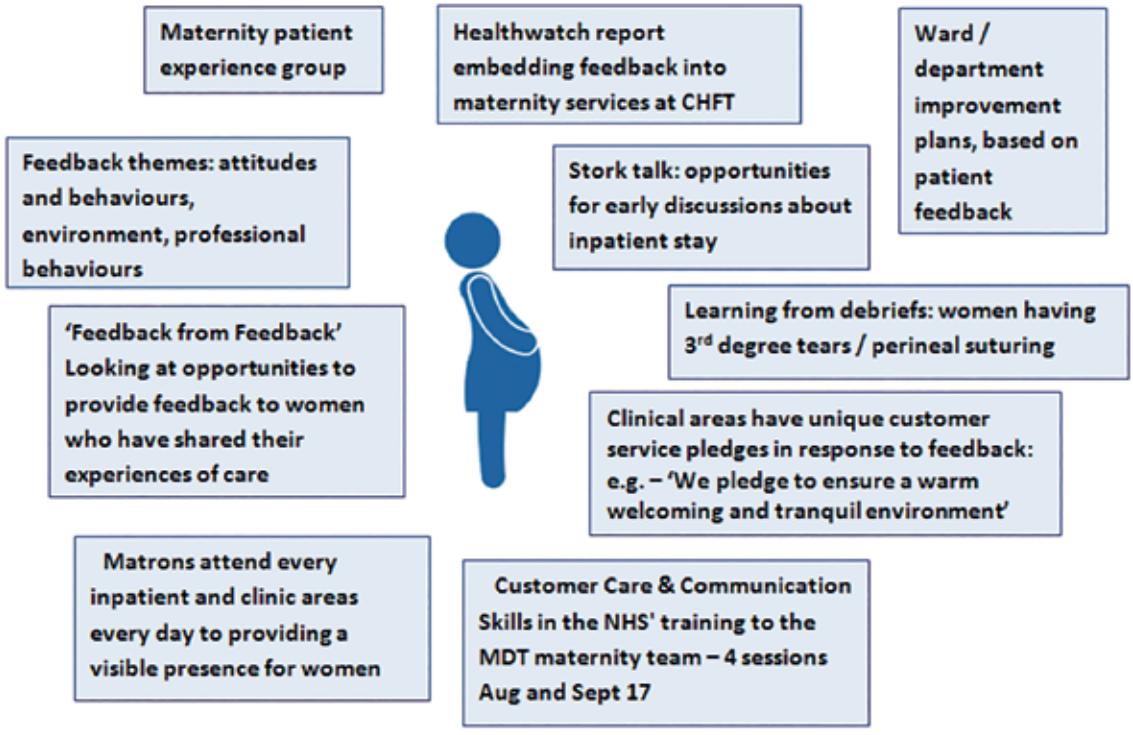


The ward team visited Sheffield Childrens Hospital to experience a youth forum which provided some useful ideas to take this forward locally. This will be the next step towards engaging with children and young people as key stakeholders enabling them to influence decisions about services and help develop a culture of participation.

1.2 Maternity patient experience work

Listening to women about their experience has been a major focus for the maternity team. This has been led through a Maternity Patient Experience Group which is made up of clinical managers. It commenced with a workshop for the multidisciplinary team providing a real chance to reflect on whether individually and as a service we 'Put the Patient First'. The focus was on Customer Care and Communication Skills, and was delivered by the NHS National Performance and Advisory Group. Examples of the study day's objectives were: understanding the impact of your own behaviour on others, how to handle challenging situations and people and understanding and managing patient expectations

A lot of work has been completed so far in response to feedback from women and their families. Going forward this work remains fundamental to influencing the service we want all our users to experience.



1.3 Community CQUIN - Introducing new measures of feedback.
Introducing new measures of feedback was determined as a quality priority by our Membership for 2016 /17 see page 7 for details. Patient feedback in the Community only has one formal mechanism, the Friends and Family Test, which doesn't always provide the detail required to really understand the issues of those areas which may be in need of improvement. A number of informal methods are used but the information is not easy to triangulate with our quality improvement process. As part of this CQUIN the trust aims to develop some specific feedback tools / questionnaires to enable assurance / measurement of the services.

Patient Surveys
NATIONAL INPATIENT SURVEY 2015
SUMMARY

Overall, the trust has performed slightly better in the 2015 survey compared to previous surveys going from 8.1 to 8.3.

In the 2015 Inpatient Survey, the trust has scored the same for the 'Waiting list and Planned Admissions' section and the 'Wait for bed' section. This is shown in the table below with a comparison of previous years and also showing an increase or decrease from the previous year's survey.

	2012	2013	2014	2015	Change from 2014 to 2015
The A&E Department	8.5	8.7	8.6	8.9	↑
Waiting list and Planned Admission	8.9	9.0	9.0	9.0	-
Wait for bed	7.4	7.2	7.6	7.6	-
The Hospital And Ward	8.3	8.3	8.2	8.3	↑
Doctors	8.4	8.5	8.6	8.7	↑
Nurses	8.4	8.4	8.5	8.6	↑
Your Care and Treatment	7.6	7.8	7.9	8.0	↑
Operations & procedures	8.1	8.3	8.6	8.7	↑
Leaving Hospital	7.2	7.2	7.3	7.4	↑
Overall View of Care and Services	4.0	4.4	5.8	5.6	↓
Overall Experience	7.9	7.8	8.1	8.3	↑
OVERALL AVERAGE	7.7	7.8	7.9	7.9	

- In the 2015 survey, overall the Trust has performed at a similar level to the 2014 survey and has continued to score highly in the patients experience on some questions including:
  - The Hospital And Ward – 'Q20 Were hand-wash gels available for patients and visitors to use?'
  - Operations & procedures – 'Q44 Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?'
  - Leaving Hospital – 'Q67 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?'
- This year, the Trust has improved significantly on hospital staff discussing additional equipment or adaptations for the patient after leaving hospital, going from 7.8 to 8.5. The trust has also scored better in this year's survey on patients being told how they could expect to feel after they have had an operation or procedure, scoring 7.1 in 2014 and 7.7 in 2015.
- Even though the Trust has stayed at a similar level for the last 4 years; some areas have not performed as well as previous years. These include:
  - The Hospital and Ward – 'Q23 Did you get enough help from staff to eat your meals?' going from 7.8 to 7.3.
  - Your Care and treatment – 'Q35 How much information about your condition or treatment was given to you?' from 8.4 to 7.8.
  - Overall – 'Q74 Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?' from 2.8 down to 2.3.

Below is a breakdown of the questions from this year's survey against previous surveys for comparison is shown below. Again, this shows a comparison between this year and the last survey to show the increase and decrease in the results. This also shows how we compare with other trusts as rated by the CQC.

		2012	2013	2014	2015	Change from 2014 to 2015	Comparison with other Trusts
The A&E Department	Q3 While you were in the A&E Department, how much information about your condition or treatment was given to you?	8.1	8.4	8.6	8.6		About the same
	Q4 Were you given enough privacy when being examined or treated in the A&E Department?	9.0	9.0	8.7	9.1		About the same
Waiting list and Planned Admission	Q6 How do you feel about the length of time you were on the waiting list before your admission to hospital?	8.5	8.9	8.6	9.0		About the same
	Q7 Was your admission date changed by the hospital?	9.1	9.5	9.2	9.1		About the same
	Q8 In your opinion, had the specialist you saw in hospital been given all the necessary information about your condition or illness from the person who referred you?	9.2	8.7	9.2	9.0		About the same
Wait for bed	Q9 From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	7.4	7.2	7.6	7.6		About the same
The Hospital And Ward	Q11&Q13 Did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?	9.1	9.0	8.7	8.8		About the same
	Q14 While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	8.6	8.4	8.3	8.5		About the same
	Q15 Were you ever bothered by noise at night from other patients?	6.9	7.0	6.4	6.6		About the same
	Q16 Were you ever bothered by noise at night from hospital staff?	7.8	8.0	8.2	8.2		About the same
	Q17 In your opinion, how clean was the hospital room or ward that you were in?	9.1	9.1	9.1	9.1		About the same
	Q18 How clean were the toilets and bathrooms that you used in hospital?	8.7	8.9	8.7	9.0		About the same
	Q19 Did you feel threatened during your stay in hospital by other patients or visitors?	9.8	9.6	9.8	9.7		About the same
	Q20 Were hand-wash gels available for patients and visitors to use?	9.7	9.8	9.8	9.8		Better
	Q21 How would you rate the hospital food?	5.1	5.1	5.1	5.5		About the same
	Q22 Were you offered a choice of food?	8.8	8.8	8.8	9.0		About the same
	Q23 Did you get enough help from staff to eat your meals?	7.3	7.3	7.8	7.3	↓	About the same
Doctors	Q24 When you had important questions to ask a doctor, did you get answers that you could understand?	8.1	8.1	8.4	8.4		About the same
	Q25 Did you have confidence and trust in the doctors treating you?	8.8	8.9	9.0	9.1		About the same
	Q26 Did doctors talk in front of you as if you weren't there?	8.4	8.4	8.5	8.6		About the same
Nurses	Q27 When you had important questions to ask a nurse, did you get answers that you could understand?	8.4	8.3	8.5	8.7		About the same
	Q28 Did you have confidence and trust in the nurses treating you?	8.9	8.8	9.0	9.1		About the same
	Q29 Did nurses talk in front of you as if you weren't there?	8.9	8.8	8.8	9.0		About the same
	Q30 In your opinion, were there enough nurses on duty to care for you in hospital?	7.5	7.6	7.5	7.5		About the same
Your Care and Treatment	Q31 In your opinion, did the members of staff caring for you work well together?	-	-	-	9.0		About the same
	Q32 Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	7.9	8.2	8.1	8.2		About the same
	Q33 Were you involved as much as you wanted to be in decisions about your care and treatment?	7.4	7.3	7.6	7.7		About the same
	Q34 Did you have confidence in the decisions made about your condition or treatment?	-	-	8.4	8.4		About the same
	Q35 How much information about your condition or treatment was given to you?	7.5	7.9	8.4	7.8	↓	About the same
	Q36 Did you find someone on the hospital staff to talk to about your worries and fears?	6.0	6.3	6.3	5.9		About the same
	Q37 Do you feel you got enough emotional support from hospital staff during your stay?	7.1	7.4	7.7	7.4		About the same
	Q38 Were you given enough privacy when discussing your condition or treatment?	8.4	8.5	8.6	8.7		About the same
	Q39 Were you given enough privacy when being examined or treated?	9.6	9.5	9.5	9.7		Better
	Q41 Do you think the hospital staff did everything they could to help control your pain?	8.2	8.2	8.5	8.4		About the same
	Q42 How many minutes after you used the call button did it usually take before you got the help you needed?	6.7	6.4	6.4	6.5		About the same

		2012	2013	2014	2015	Change from 2014 to 2015	Comparison with other Trusts
Operations & procedures	Q44 Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?	8.7	9.1	9.1	9.2		About the same
	Q45 Beforehand, did a member of staff explain what would be done during the operation or procedure?	8.1	8.5	8.9	8.7		About the same
	Q47 Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?	8.3	8.6	9.0	9.0		About the same
	Q46 Beforehand, were you told how you could expect to feel after you had the operation or procedure?	6.7	7.0	7.1	7.7	↑	About the same
	Q49 Before the operation or procedure, did the anaesthetist or another member of staff explain how he or she would put you to sleep or control your pain in a way you could understand?	9.0	8.9	9.4	9.3		About the same
	Q50 After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	7.5	7.9	8.0	8.1		About the same
Leaving Hospital	Q51 Did you feel you were involved in decisions about your discharge from hospital?	6.6	7.0	6.9	7.2		About the same
	Q52 Were you given enough notice about when you were going to be discharged?	7.2	7.3	7.5	7.4		About the same
	Q53&Q54 On the day you left hospital, was your discharge delayed for any reason? What was the MAIN reason for the delay?	6.7	7.2	7.0	6.9		About the same
	Q55 How long was the delay?	8.0	8.4	8.1	8.2		About the same
	Q57 After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?	-	-	-	7.4		About the same
	Q59 Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	6.9	7.2	6.7	6.9		About the same
	Q60 Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	8.3	8.3	8.2	8.3		About the same
	Q61 Did a member of staff tell you about medication side effects to watch for when you went home?	5.1	4.4	4.6	5.0		About the same
	Q62 Were you told how to take your medication in a way you could understand?	8.3	8.2	8.3	8.3		About the same
	Q63 Were you given clear written or printed information about your medicines?	7.9	7.8	7.8	8.0		About the same
	Q64 Did a member of staff tell you about any danger signals you should watch for after you went home?	5.2	5.3	5.4	5.2		About the same
	Q65 Did hospital staff take your home or family situation into account when planning your discharge?	7.0	7.1	7.7	7.4		About the same
	Q66 Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?	6.0	5.8	6.3	5.9		About the same
	Q67 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	8.0	8.2	8.4	8.3		About the same
	Q68 Did hospital staff discuss with you whether you would need any additional equipment in your home or any adaptations made to your home, after leaving hospital?	8.3	7.8	7.8	8.5	↑	About the same
	Q69 Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital? (e.g. Services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)	8.6	8.6	8.4	8.7		About the same
Overall	Q70 Overall, did you feel you were treated with respect and dignity while you were in the hospital?	8.8	8.7	9.1	9.1		About the same
	Q71 During your time in hospital did you feel well looked after by hospital staff?	-	-	8.9	9.0		About the same
	Q72 Overall...	7.9	7.8	8.1	8.3		About the same
	Q73 During your hospital stay, were you ever asked to give your views on the quality of your care?	1.4	2.0	2.4	2.0		About the same
	Q74 Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?	1.9	2.3	2.8	2.3	↓	About the same
Total	**Overall Average**	7.7	7.8	7.9	7.9		

Other National Surveys:

2. Other patient experience feedback

3.2 National Cancer Patient Experience Survey - 2016 Results

A survey of cancer patients is carried out each year with results published at both an overarching level as well as for each tumour site. These results are analysed to assess comparative performance, based on a calculation of "expected ranges". This means that Trusts are flagged as outliers only if there is statistical evidence that their scores deviate (positively or negatively) from the range of scores that would be expected for Trusts of the same size. The report for CHFT identified that for the majority of questions the Trust had an overall level scored within the expected range, with the exception of 3 questions, scoring lower for 2 questions (Q17 and Q22) and higher for 1 question (Q56)

Questions which scored outside expected range

			2015 Case-mix Adjusted			
Question		Number of responders for this Trust	2015 Percentage for this Trust	Lower limit of expected range	Upper limit of expected range	National Average Score
Clinical Nurse Specialist						
Q17	Patient given the name of the CNS who would support them through their treatment	393	84%	86%	94%	90%
Support for people with cancer						
Q22	Hospital staff gave information on getting financial help	227	47%	47%	63%	55%
Your overall NHS care						
Q56	Overall the administration of the care was very good / good	404	93%	85%	92%	89%

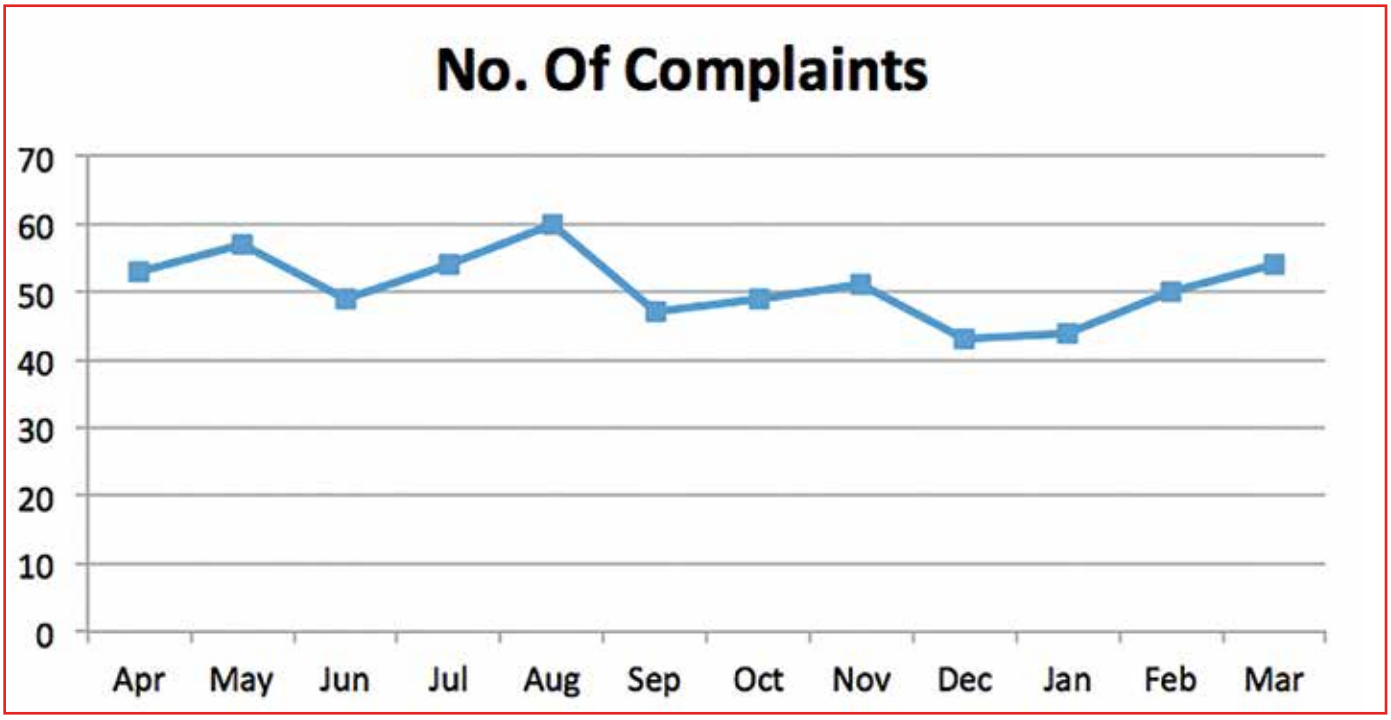
The Trust's lead cancer nurse is working with each cancer team to develop individual plans based on their results. Examples of actions taken for the above questions are the development of a new CNS leaflet to be given to patients and also a new financial leaflet to be issued via the information pack given out at the time of diagnosis.

3.3 National surveys were carried out during 2016/17

Three further surveys will be published this year:
Three further surveys will be published this year:

- National inpatient survey – published July 2017
- Children and young people's survey – published October 2017
- Accident and emergency survey – published July 2017

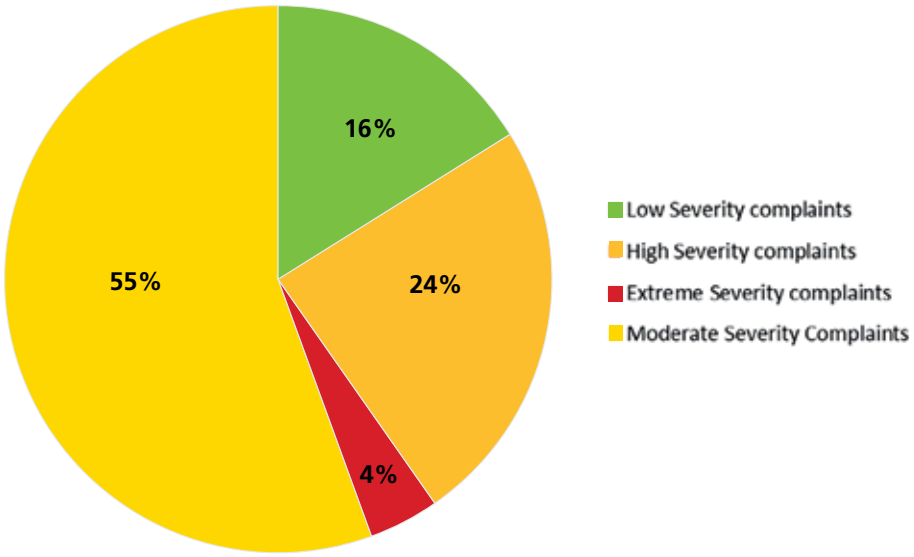
Complaints (Type and Severity)
In 2016/17 the Trust received a total of 610 complaints, a 7% decrease in complaints received from 2015/16 to 2016/17. This contrasts with a regional increase of 7% complaints for hospital and community health service complaints, based on information for April to December 2016 from national complaints returns, KO41s (Source: NHS Digital). It also reverses the upward trend in complaints which increased for the Trust by 6% in 2015/16 and 8% in 2014/15.



The profile of the spread of complaints received by month shows a slight dip in the months of September and December and January, which is in line with the previous year and normal patterns of complaints activity. There were between 44 and 60 complaints received a month during the year.

Severity of Complaints Received
Complaints are triaged and graded on receipt for severity. The initial grading is determined by the Patient Advice and Complaints Department based on the content of the complaint.

The majority of complaints received in 2016/17 are graded as yellow severity; no lasting harm (58%). Whilst yellow complaints also made up the majority of complaints received in 2015/16, there has been a 6% decrease. 4% of complaints received were graded red, this is a 2% increase from 2015/16.

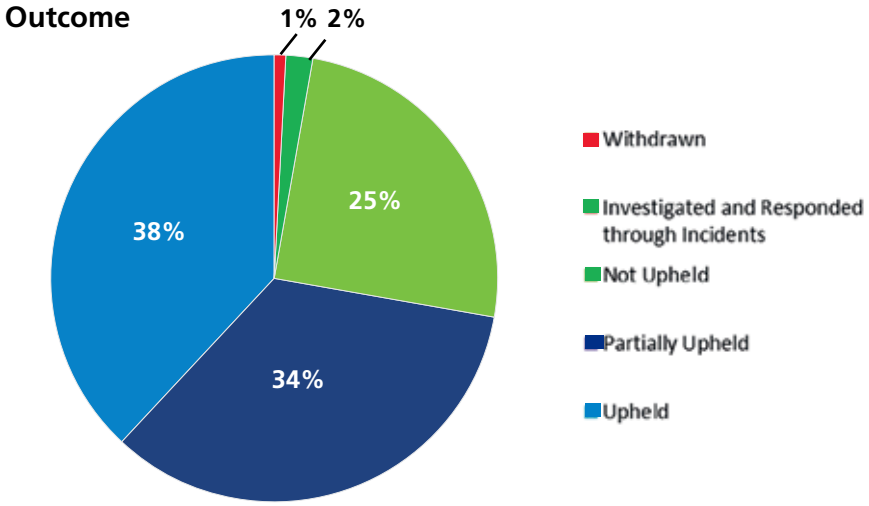


Red complaints data
A red complaint is a case where the patient or their family feel the action or inaction of the Trust have caused the death or significant distress and non-reversible harm to the patient and their family or a significant impact on patient experience.

During 2016/17 the Trust received a total of 25 red complaints. This is an increase of 9 complaints from 2015/16. The Trust closed 32 red complaints in 2016/17; of these 27% were upheld and 13% were investigated as a serious incident.

Acknowledgement time
The Trust has performed consistently well at acknowledging all complaints within the 3 working days with 98% of the complaints received in 2016/17 being acknowledged within 3 working days.

Complaints closed
The Trust closed a total of 690 complaints in 2016/17 which is a 4% increase from 2015/16. The pie chart below shows the summary of outcomes of complaints investigated in 2016/17. Of the 690 complaints closed: 38% were upheld, 34% were partially upheld (NHS Digital counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%) and 25% were not upheld, 2% were investigated and responded to through incidents, and 1% were withdrawn.



The Trust re-opened a total of 72 complaints in 2016/17. This is an 8% decrease from 2015/16, which would suggest that the quality of complaints responses has improved.

Timeliness of Complaints Responses
There has been significant work undertaken by the Trust in 2016/17 to improve the timeliness of responses to complainants. During the month of November 2016 the Trust closed a total of 109 complaints reducing the backlog of complaints from 73 to 5, a reduction of 93%.

Processes have been put in place to closely monitor timescales and escalate any delays in response to ensure that all complainants receive a timely response.

Whilst the Trust still has a small proportion of complaints responses which are overdue, there are no longer any responses which are over 4 weeks overdue.

The top three subjects of complaints for the Trust are as follows:

Subject	Percentage
Clinical Treatment	22%
Communication	20%
Patient Care (including Nutrition and Hydration)	16%

The above have been the top three complaint subjects throughout 2016/17. Both clinical treatment and communication were in the top three in 2015/16. The Trust annual complaints report for 2016/17 provides a breakdown of complaints themes by division.

Parliamentary and Health Service Ombudsman Complaints (PHSO)
The Parliamentary and Health Service Ombudsman (PHSO) investigate complaints where an organisation has not been able to resolve the complaint at a local level. The PHSO have broadened their review process and have considerably increased the numbers of cases that they consider.

The table below shows figures relating to the Trust; at the time of writing only quarter 2 figures for 2016/17 were available:

	Q3 2015/16	Q4 2015/16	Q1 2016/17	Q2 2016/17
Number of Complaints Received by PHSO	**9**	**12**	**18**	**14**
Number of Complaints accepted for investigation by the PHSO	**2**	**7**	**7**	**3**
Number of Complaints the PHSO Upheld or Partly Upheld	**2**	**2**	**2**	**2**
Number of Complaints not upheld	**5**	**1**	**1**	**4**

Quarter 3 & 4 data has not yet been published.

10 cases were accepted for PHSO investigation between April and September 2016. Of the cases concluded by the PHSO in the first six months of 2016 /17, 5 complaints were not upheld and 4 were upheld /partially upheld.

Learning From Complaints
The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

Information on learning from complaints for each division is given below. One specific example relating to attitude within Radiology Services is described here which addresses a communication issue.

A complaint was received regarding the attitude of a member of staff in the X-ray Department at Huddersfield Royal Infirmary. The patient overheard staff discussing their rota as the member of staff involved was in earshot of the waiting room.

This was deemed not acceptable and the staff member involved was reminded of proper conduct whilst at work. Following on from this complaint two patient experience events were held with all Radiology staff, including the individual concerned in the complaint.

With permission from the complainant the complaint letter was read to the attendees so staff could realise exactly how the patient felt; this lead onto an interactive session with staff which included excerpts from the Radiographers Code of Conduct.

Since the sessions have run there have been no further complaints of this type for the Radiology Department.

Learning:

Medicine		
Issue:	**Findings:**	**Learning:**
Missed Fracture: Missed fracture in the Emergency Department and poor attitude. Delay to treatment due to failure to identify fracture on first attendance	Fracture was missed by the Junior Doctor; however, this was picked up on review by the senior doctor and patient called back.	Fracture was difficult to diagnose junior doctor has reviewed x-rays to learn from his mistake to improve his practice.
Attitude of Staff: Complaint against consultant, regarding lack of empathy, being dismissive, rude and judgmental towards patient causing the patient upset and anxiety.	Consultant was not aware of how he had come across in clinic. The consultant was apologetic.	Reflection on the complaint has made the consultant consider his communication with patients and how this may be perceived.
Delays: Complainant raised concerns regarding her terminally ill mother's care whilst in Emergency Department, and the time spent waiting for a bed.	There was a delay in staff admitting the patient onto the ward as Emergency Department was busy during patient's admission.	Whilst delays were unavoidable this was not effectively communicated to the patient. Had it been communicated been better at the time, patient would have been aware of the reasons for the delays.
Family and Specialist Services		
Issue:	**Findings:**	**Learning:**
Complications during birth: Baby born by forceps delivery possibly suffered broken collar bone which went undiagnosed.	Mother not informed of risks associated with procedure. Once diagnosed, no communication regarding follow up appointment received.	All staff to ensure that risks of shoulder dystocia are described to the parents following delivery and what to look out for longer term. All consultants to ensure that complications of shoulder dystocia are included within the labour debrief meeting, where applicable.
Cancelled Appointments: Complaint against Appointment Centre with regards to cancelled appointments and incorrect appointment planning	Patient's appointment was booked incorrectly.	Feedback was shared with the appointment team to take this as a learning opportunity in terms of patient experience.
Prescription Error: Cream containing peanut oil was prescribed to patient with allergy	Medication dispensed to patient which included an ingredient to which the patient had a known allergy	Well Pharmacy staff reminded to ensure that the dispensing label is not positioned over critical information on any dispensed medicines. All Trust Pharmacy staff briefed on what should happen with allergy checks including non-drug allergies. To ensure a wider learning from the incident for all Trust prescribers, nurses and pharmacists a bulletin is to be prepared and shared within the organisation. Shared at the junior doctor training on Medicine Safety and was part of discussion at the Medication Safety Group. Reviewed plans for EPR and prescribing system confirmed allergies once recorded will be permanently recorded on the EPR system and will always be visible on the header for each patient, irrespective of where you are in the record. Include learning within Trust Medicine Code which covers medicines prescribed, administered and dispensed.

Issue:	Findings:	Learning:
Accurate Recording: Concern that incorrect birth weight recorded.	Baby weight was recorded in error by a student midwife which resulted in concerns that baby had lost 13% in weight at next visit which has caused stress and anxiety to family	All student midwives to request second check of initial birth weight; staff to encourage parents/families to photograph initial birth weight. All paediatric team reminded of which low milk formulas are available without prescription when recommending for babies who have been discharged.
Parliamentary Health Service Ombudsman (PHSO)		
Issue:	**Findings:**	**Learning:**
Poor Treatment & Care: The complainant raised issues relating to communication, nutrition, failure to follow NICE guidelines, lack of care and compassion, delays in referrals, medication and discharge plans in relation to a relative.	Overall clinical treatment was in line with established good practice. Failings on the part of the Trust in relation to Discharging Planning and nutrition of the patient.	Safety huddles are now in place at every handover to improve communication with the team. At multi-disciplinary team (MDT) communications now go out on blue paper to highlight information regarding discharge and plans of care. This gives clear communication to patients and relatives. Dieticians are now being invited to MDT, when required.
Prescribing Errors: The Trust had prescribed incorrect medication which caused atrial fibrillation. Several doctors and nurses misread the patient's notes and neglected information about the patient's heart condition.	Whilst the PHSO accepted the Trust's reasons why the physician did not know about the patient's heart condition they considered this to be maladministration, which lead to confusion by the clinicians and repeatedly telling the patient wrong information. The Trust had wrongly prescribed the patient aspirin. The PHSO awarded the patient the sum of £200.	The PHSO report has been share with the directorate team involved to ensure clear reporting.

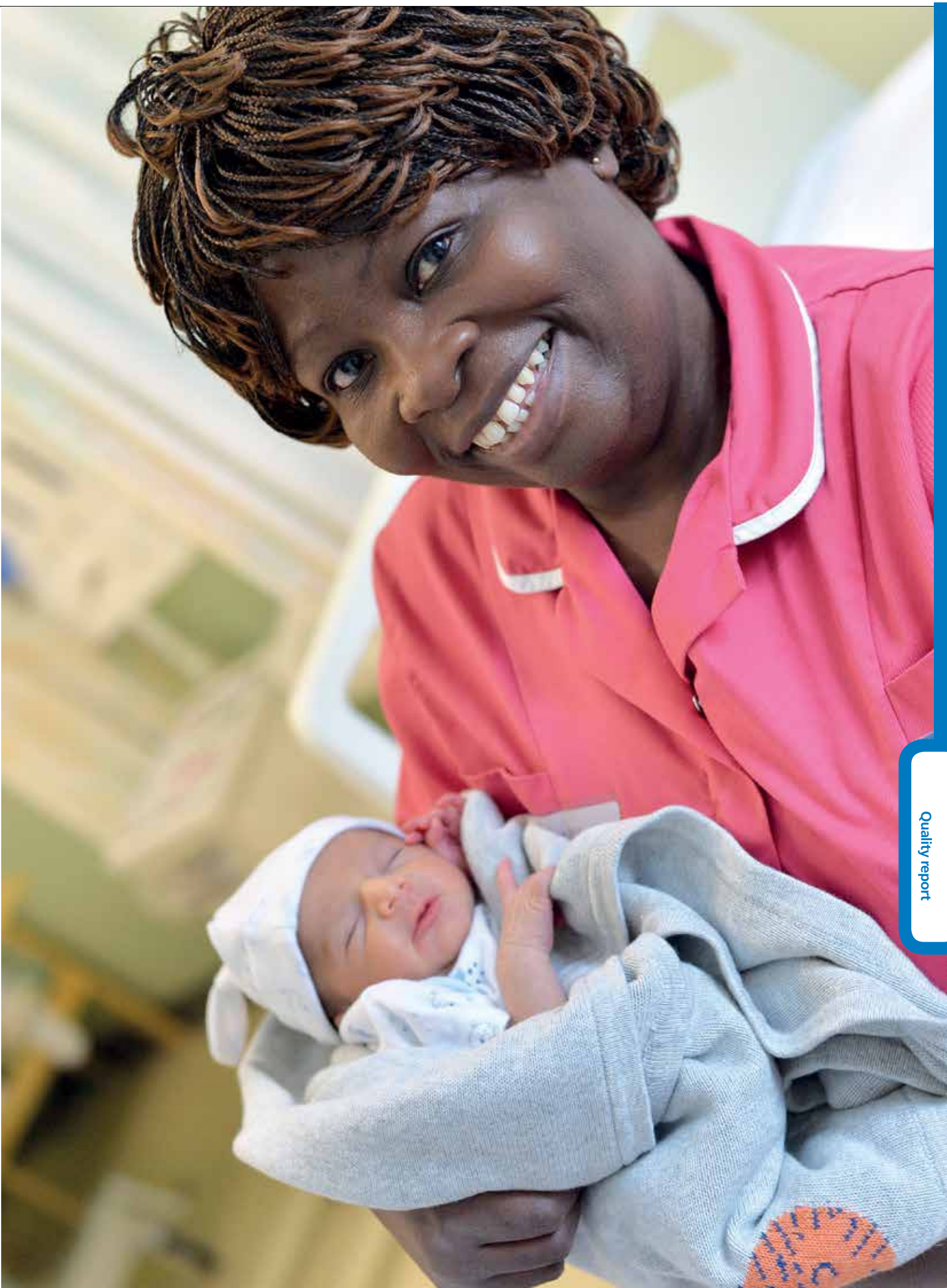
Complaints - Areas for Improvement

An update against the key priorities for 2017/18 for the complaints and patient advice service are:

- Sustain timely responses to complainants
- Delivering complaints training to complaints investigators to improve the quality of investigations and support staff in the effective management of complaints
- Continue to focus on quality responses that address all aspects of complaints and analyse reasons for any re-opened complaints
- Improve learning from complaints, which is one of the three Trust's quality improvement priorities for 2017/18
- Improve identification of sharing and learning from complaints within the Trust learning from adverse events framework
- Implement recommendations from an internal audit report on complaints and implement any recommendations made
- Undertake a go see visit to a provider to see what we can learn from a Trust that has made significant improvements
- Develop reporting of Patient Advice and Liaison Service (PALS) concerns

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%	91.81%	Yes
Access 2	Maximum time of 18 weeks from point of referral to treatment in aggregate- non admitted**	95%	98.36%	Yes
Access 3	Maximum time of 18 weeks from point of referral to treatment in aggregate- patients on an incomplete pathway**	92%	95.14%	Yes
Access 4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge	95%	94.20%	No
Access 5	All cancers: 62-day wait for first treatment from: • Urgent GP referral for suspected cancer • NHS Cancer Screening Service referral	 85% 90%	 90.3% 91.2%	 Yes Yes
Access 6	All cancers: 31-day wait for second or subsequent treatment , comprising: • Surgery • Anti-cancer drug treatments • Radiotherapy	 94% 98% n/a	 99.2% 100%	 Yes Yes
Access 7	All cancers: 31 day wait from diagnosis to first treatment	96%	99.5%	Yes
Access 8	Cancer: two week wait from referral to date first seen, comprising: • all urgent referrals (cancer suspected) • for symptomatic breast patients (cancer not initially suspected)	 93% 93%	 97.6% 95.3%	 Yes Yes
Outcomes 16	Clostridium difficile – meeting the C. difficile objective	21	6	Yes
Outcome 21	Data completeness: community services, comprising: • Referral to treatment information • Referral information • Treatment activity information	 50% 50% 50%	 100% 98.29% 100%	 Yes Yes Yes
**Due to the way in which data is collated and validated the Trust is aware that performance may in fact be better than the year end performance states.				



Feedback from commissioners, overview and scrutiny committees and Local Healthwatch, Governors and local providers

Response from Greater Huddersfield and Calderdale Clinical Commissioning Groups

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 within CHFT, we note the continued commitment to quality despite the financial challenges and increasing demand. The account describes progress in many areas against 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 2016/17, and welcome the improvement, in particular around the reduction in the number of falls through the introduction of safety huddles and look forward to seeing patient safety improve further in the coming year. We also note the work to develop feedback mechanisms in Community Services and agree that the Friends and Family test gives limited information in terms of qualitative feedback.

Your continued achievement in relation to maintaining the cancer waiting times above the national average is commendable, as is the aim to see fast track patients within 7 days, though as commissioners we recognise the challenge of this in some service areas. The CCGs acknowledge the focussed work that has taken place around Stroke services and recognise the need for further work required in relation to the two indicators described within the account, but welcomes the Trusts commitment to learn through invited independent service reviews.

The work around improving patient experience is a welcome inclusion and again is evidence that the organisation is one of listening and learning. We note the continued improvement in Friends and Family Test response rates and the local quality improvement projects in relation to the work undertaken to gather opinion in maternity and children's services. As Commissioners we look forward to working together to strengthen patient experience in 2017/18.

We note the open account of the Care Quality Commission (CQC) inspection and outcome and the improvements made against the action plan thus far, we are pleased to have been able to support this work by our participation in the mock CQC inspections.

The CCGs are pleased to see that the priorities for 2017/18 will support system wide improvement:

- *Sepsis screening*
- *Discharge planning*
- *Learning from complaints*

The rationale for why these have been chosen, the work to be carried out and what the Trust is trying to achieve is clearly articulated and supported by the commissioners. The priorities are aligned with the local improvement work and we welcome the plan for commissioners to work closely with the Trust, we will continue to visit the hospitals and participate in the "go see" reviews of the work you are undertaking. This is a welcome demonstration of your willingness to be transparent.
The account could be further strengthened by the inclusion of some narrative around the difficulties the Trust continues to experience in recruitment and retention of both medical and nursing staff, and the challenges of improving care and patient safety through the organisation learning from incidents.

The CCGs will of course continue to support you over the coming year in achieving the quality improvement priorities set out in the account.
Yours Sincerely

PP
Dr Majid Azeb, Chair Calderdale CCG Quality Committee

Dr Jane Ford, Chair Greater Huddersfield CCG Quality and Safety Committee

Response from Healthwatch in Kirklees and Calderdale

Healthwatch in Kirklees and Calderdale have worked in partnership with CHFT throughout the year.

We have worked in partnership to understand better people's views of maternity services. And at the same time we have challenged the Trust when patients complain to us about their experiences.

We value the open and honest relationship where we can work together, and criticise where appropriate. We recognise the financial pressure that the organisation faces every day, and the commitment that they have to quality and patient safety is visible in all of our dealings with the Trust."

Rory Deighton Healthwatch Kirklees
Helen Wright Healthwatch Calderdale

Response from Kirklees Health and Social Care Scrutiny Panel

Thank you for your email dated 12 April 2017 inviting comment from the Kirklees Health and Social Care Panel on the draft 2016/17 Quality Account for Calderdale and Huddersfield NHS Foundation Trust.

Please note that due to the tight timescales the Panel hasn't been able to have a full discussion on the Quality Account and this is reflected in the level of comments received which is summarised below:

"The Panel welcomed the opportunity to comment but wished to highlight that due to the relatively short notice that was given to respond there wasn't sufficient enough time for the Panel to have a full and comprehensive discussion. This constraint on time and the gaps in some of the data means that comments will be restricted.

The Panel noted that last year's improvement priorities had yielded some encouraging results although it was felt that it would have helped if the outcome data could have been clearer and more explicit. In addition the Panel is still unclear if the Trust is a statistical outlier in the three priority domains.

The Panel welcomed the decision to continue to monitor all previous priorities as part of the Trust's on-going improvement programmes and felt that it would be helpful if the Trust could provide a regular update to stakeholders on progress of these priority areas.

The Panel noted the priorities for 2017/18 and was generally supportive of the range of areas they will cover and felt that the numerical targets were sufficiently challenging and clear.

The Panel welcomed the inclusion of learning from complaints as a 2017/18 priority and acknowledged the importance of learning from patients' experiences to improve the quality of care that the Trust provides. In addition the Panel believed that maintaining a strong focus on customer feedback is equally as important and would wish to see the Trust continue to use customer feedback to help inform and strengthen its approach to delivering high quality and safe care.

The Panel welcomed the assurance from the Board that demonstrated a commitment to innovation and development although it was felt that more could have been done to provide sufficient evidence of achievement.
The Panel noted a number of references to work being carried out as a result of a strategy or review and felt that it would have been helpful to include a brief overview of the outcomes from the work.

The Panel noted that there is minimal information on the local plans to reconfigure healthcare in the hospital and community settings which continues to be of significant interest to the Panel and local residents.

The performance of the Trust remains a key issue and area of focus for the Panel and ensuring that patients receive high quality and safe care is an integral part of the scrutiny work programme. The Panel hope that throughout 2017/18 the Trust will discuss and update the Panel on progress of its priority areas."

Response from Calderdale Overview and Scrutiny Committee

Feedback requested but not received by 25 May 2017.

Response from the Governors

Membership Council response to CHFT Quality Accounts 2016-2017

The Membership Council is actively involved in the development and quality of patient services at the Trust. The Membership Council comprises elected representatives of the patient and staff bodies, together with councillors nominated from the Trust's partner organisations. As such, it is well placed to offer an objective and rounded view of the Trust's services to patients.

Membership Councillors become deeply involved in the quality of care at both hospitals, in formal meetings and informal and wide ranging walkabouts; to go see for ourselves. The key point is that we are able to ask in-depth questions about quality concerns and find reassurance on behalf of members, that the Trust is doing everything possible to "put the patient first."

In a complex organisation, providing wide-ranging services for some 459,000 outpatient visits, 151,000 attendances at A&E and over 120,000 in-patient stays, there will be some level of complaints. The Membership Council regularly reviews the processes for dealing with these complaints and the follow-up actions. In our experience, staff reply with candour and genuinely seek to implement "lessons learned'. The Trust is always looking to improve safety and quality of performance through proven care pathways, through staff training and through improved facilities. We note how the Trust is responding positively to the CQC report and putting robust long term measures in place. Where problems have persisted, we see that the Trust has sought the assistance of the Royal College of Physicians through "invited service reviews" and looks to act on their professional recommendations.

In the world of the NHS, where media reporting often focuses on the negative, we have introduced a reporting page on "positive achievements" into our MC meetings. We believe this is important to bring about balance in our role. We would particularly like to all thank staff for their compassionate care and we applaud our clinical, nursing, managerial and support staff on their dedicated and enthusiastic endeavours towards great patient outcomes. We see the huge number of thank-you cards displayed in the wards and we congratulate those staff recognised through the "Celebrating Success Awards". We note in these accounts, that more staff feel they are able to contribute to improvements at work, the manifestation of which we regularly see for ourselves.

Membership Councillors play an important part in the governance arrangements of the Trust, and through this, help to provide oversight of the quality of patient services. Each of the formal sub-committees of the Trust's board has Membership Councillors as part of their make-up, and both the Quality Committee, and the Audit & Risk Committee routinely consider the quality of patient services. In addition, joint workshops are held between the Membership Council and the Trust board where Membership Councillors are able to hold to account the non-executive directors for the performance of the board.

The views and opinions of Membership Councillors are an intrinsic part of the selection process to choose the quality indicators and priorities for the Trust. Comprehensive evidence is presented to us throughout the year as to progress against the existing priorities, and then we, and the Trust's membership, are canvassed for our views on what should be the quality priorities for the forthcoming year.

Membership Councillors are supportive of the efforts of Trust staff to improve the quality of services for patients. We recognise that not everything is perfect but the direction of travel is positive and we endorse these Quality Accounts.

Peter Middleton
Deputy Chair and Lead Governor
CHFT Membership Council

Response from South West Yorkshire Partnership NHS Foundation Trust

As a partner of the Trust, we were pleased to receive and asked to comment on Calderdale and Huddersfield NHS Foundation Trust draft Quality Account for 2016/17.

The Quality Account provides an assessment of the levels of quality provided by the Trust, describing the progress made in many areas together with comparisons against other organisations. It was good to note the positive progress on the three improvement priorities for 2016/17, especially the further impact of the roll out of the safety huddles on reducing the number of falls. The selection of the quality priorities for 2017/18 involved the Members Council, which we attend and of which we are members. Priority one around sepsis screening for in-patients, which is a significant cause of mortality and morbidity in the NHS, feels appropriate and builds on the work started in 2016/17.

We recognise the efforts by the Trust to address the areas in the CQC inspection, where CHFT was rated as "requires improvement". Alongside positive areas of practice and the Trust's rating of "good" for caring and being responsive, the Trust's action plan shows they have taken the inspection as an opportunity for learning and improving.

We note the plans to reconfigure healthcare in hospitals and community setting across Calderdale and Greater Huddersfield with a view to improving quality and safety. These changes will be delivered in the current challenging financial environment and a period with increasing demands for services. This means all planned changes should be assessed for their impact on quality, with good involvement from all partners.

As a provider organisation we welcome CHFT's commitment to working to ensure joined up services with partners and we look forward to working with CHFT in the future for the benefit of our local communities.

Rob Webster
Chief Executive

Response from Locala
Feedback requested but not received by 25 May 2017.

Statement of directors' responsibilities in respect of the quality report

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

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation Trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 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 2016 to 25 May 2017
  – papers relating to Quality reported to the board over the period April 2016 to 25 May 2016
  – feedback from commissioners dated 28 April 2017
  – feedback from governors dated 26 April 2017
  – feedback from local Healthwatch organisations dated 3/05/2017|
  – feedback from Kirklees Overview and Scrutiny Committee dated 28/04/2017
  – the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31/05/2017 (planned date)
  – the 2015 national patient survey June 2017
  – the 2016 national staff survey 07/03/2017
  – the Head of Internal Audit's annual opinion over the trust's control environment dated 25 May 2017

Feedback was requested from Calderdale Overview and Scrutiny Committee and Locala on 12 April 2017 but has not been received by 25 May 2017.

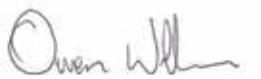
CQC inspection reports dated 15 August 2016

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

.....Chairman



..... Chief Executive

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CALDERDALE & HUDDERSFIELD NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Calderdale & Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale & Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance consist of the following two national priority indicators (the indicators):

- percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period; and
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.
-

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

Respective responsibilities of the directors and auditors

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

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

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Detailed requirements for quality reports for foundation trusts 2016/17 ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Requirements for external assurance for quality reports for foundation trusts 2016/17.

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

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

- Board minutes and papers for the period April 2016 to May 2017;
- papers relating to quality reported to the board over the period April 2016 to May 2017;
- feedback from commissioners, dated 28 April 2017;
- feedback from governors, dated 26 April 2017;
- feedback from local Healthwatch organisations, dated 3 May 2017;
- feedback from the Kirklees Overview and Scrutiny Committee, dated 28 April 2017;
- feedback from the Calderdale Overview and Scrutiny Committee, requested on 12 April 2017;
- feedback from Locala requested on 12 April 2017;
- the Trust's latest complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey, dated 2016;
- the latest national staff survey, dated 2016;
- Care Quality Commission Inspection, dated August 2016;
- the 2016/17 Head of Internal Audit's annual opinion over the trust's control environment, dated May 2017; and
- any other information included in our review.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Calderdale & Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2017, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Calderdale & Huddersfield NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

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

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

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

Limitations

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

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

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Calderdale & Huddersfield NHS Foundation Trust.

Basis for qualified conclusion

Our testing of the 'percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' indicator identified that the Trust's processes were not accurately identifying the correct pathways. We identified cases which had been included in the calculation of the indicator which were not pathways. In addition the Trust undertakes a validation process for this data, this is a targeted methodology to ensure the Trust achieves the required performance and may not cover the total population in any one month.

As a result we are not able to conclude that nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017, the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator has been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

Qualified conclusion

Based on the results of our procedures, except for the effects of the matters described in the 'Basis for qualified conclusion' section above, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2017:

- 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 remaining indicator in the Quality Report subject to limited assurance, the 'A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge' indicator 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 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

25 May 2017

Appendix A: 2016/17 Clinical Audit

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in/participated in for which data collection was completed during 2016/17, 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 √**	**% Cases submitted**
Child health programme (CHR-UK)	No	NA	NA	NA
Diabetes in pregnancy audit 2016	Yes	Yes	100%	100%
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	Yes	465	100%
Paediatric intensive care (PICANet)	No	NA	NA	NA
BTS paediatric pneumonia	Yes	Yes	100%	100%

Acute				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases Submitted**
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	Yes	100%	On-going
National Joint Registry (NJR)	Yes	Yes	258	100%
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	Yes	All	100%
National emergency laparotomy audit (NELA)	Yes	Yes	149	100%
RCEM severe sepsis & septic shock 2016	Yes	Yes	All cases in time period	100%

Blood and transplant				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:				
2015 Audit of transfusion in children and adults with Sickle Cell Disease	Yes	Yes	0	0
2015 Audit of Patient Blood Management in adults undergoing elective, scheduled surgery	Yes	Yes	37	100%
2016 Audit of Red Cell & Platelet transfusion in adult haematology patients	Yes	Yes	30	100%

Cancer				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Bowel cancer (NBOCAP)	Yes	Yes	235	100%
Lung cancer (NLCA)	Yes	Yes	All cases in time period	100%
Oesophago-gastric cancer (NAOGC)	Yes	Yes	All cases in time period	100%
National Prostate Cancer Audit	Yes	Yes	337	100%

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	N/A	N/A
Cardiac arrhythmia (HRM)	Yes	Yes	100%	On-going
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No	N/A	N/A	N/A
Coronary angioplasty (NICOR)	Yes	Yes	100%	On-going
Heart failure (HF)	Yes	Yes	100%	On-going
National Cardiac Arrest Audit (NCAA)	Yes	Yes	141 YTD	on-going
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	Yes	256	100%

Long term conditions				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	Yes	On-going	On-going
Diabetes (Paediatric) (NPDA)	Yes	Yes	100%	100%
Inflammatory bowel disease (IBD) Registry	Yes	Yes	On-going	On-going
Renal replacement therapy (Renal Registry)	No	N/A	N/A	N/A
National Complicated Diverticulitis Audit (CAD)	Yes	Yes	On-going	All cases
National Ophthalmology Audit	Yes	Yes	2419	100%
BTS Adult Asthma	Yes	Yes	100%	100%
RCEM moderate & severe acute asthma 2016	Yes	Yes	All cases in time period	100%

Mental Health				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Prescribing observatory for Mental Health(POMH-UK)	No	N/A	-	-

Older People				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Sentinel Stroke (SSNAP)	Yes	Yes	All	On-going
Rheumatoid and early inflammatory arthritis (NCAPOP) 2016 cohort	Yes	Yes	All cases in time period	All cases in time period
National audit of Dementia 2016 (round 3)	Yes	Yes	50	100%
BTS COPD secondary care	Yes	Yes	All cases in time period	100%
BTS Pulmonary Rehab	Yes	Yes	on-going	on-going

Other				
Audit title	**Trust Eligible for Involvement**	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Specialist Rehab for patients with complex needs	No	N/A	-	-
UK Cystic Fibrosis Registry	No	N/A	-	-
Learning Disability Mortality Review (LeDeR)	Yes	Yes	7	100%
Elective surgery (National PROMs Programme)				
Groin hernia	Yes	Yes	268	On-going
Hip replacements	Yes	Yes	487	On-going
Knee replacements	Yes	Yes	466	On-going
Varicose veins	Yes	Yes	237	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:				
Mental Health in Adults	Yes	Yes	9	90%
Chronic neuro-disability (cerebral palsy)	Yes	Yes	3	100%
Non-Invasive Ventilation Study	Yes	Yes	5	50%
Child Health Review -a study into the care of mental Health conditions in young people	Yes	Yes	Ongoing	Ongoing

The Trust did not take part in one national audit as detailed below.

Name of audit	Reason
National smoking cessation audit 2016 (BTS)	Not taking part due to capacity issues – re Dr A Graham 15/3/16. Discussed at CEAG June 2016. MDB written to AG. Data collection deadline passed before any decisions made.

The reports of 39 national clinical audits were reviewed by the provider in 2016/17 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

NCEPOD Management of Acute Pancreatitis Study 2015
The NCEPOD report examines the quality of care received by patients admitted to hospital with a primary diagnosis of acute pancreatitis during the first 6 months of 2014. Acute pancreatitis is caused by an acute inflammatory process affecting the pancreas gland. The main causes are gallstones and an excess of alcohol. Most hospitals in the United Kingdom serving a population of 300,000 – 400,000 people admit around 100 patients with this condition each year. The condition can be mild and self-limiting but can also be a severe illness causing multiple organ failure.

Study Objectives:
To identify the remediable factors in the quality of care provided to patients treated for acute pancreatitis (AP).
The primary aim will be addressed by looking at a number of key areas including:

- Initial resuscitation and treatment
- Criteria to determine severity of acute pancreatitis
- The appropriateness of investigation request pattern and ITU support requests
- Timeliness of transfer to HDU/ITU
- Appropriateness of ERCP
- Timeliness of gallstone treatment (Laparoscopic cholecystectomy or ERCP)
- Timeliness of transfer to a tertiary centre
- Radiology imaging and intervention
- Use of step-up care / timing of interventions
- Inequalities in treatment
- Secondary vs Tertiary
- Geographical
- Appropriateness of antibiotic usage
- Networks, formal/informal

Summary results

- 34 patients submitted by Calderdale & Huddersfield Foundation Trust
- NCEPOD results show that early warning score, NEWS, is not always fully completed for all patients; however CHFT results show 100% compliance for all patients
- All patients in CHFT had a critical care review and were transferred appropriately to HDU if required
- 80% of all patients at CHFT had a Cholecystectomy within 2 weeks of referral. Aim for this to be 100%

Recommendations:

- All patients have NEWS scoring
- 100% of patients to have a Cholecystectomy within 2 weeks of referral– mild, severe, when clinically appropriate for all patients
- All patients with alcohol aetiology should be seen by alcohol services on admission. (Barriers to this recommendation is that CHFT do not have inpatient alcohol services so unachievable for CHFT)
- Formal AP regional network – no guidance/funding on how we take this forward.

Action Plan

Recommendation	Action required	Person responsible	Deadline
Local pancreatic guideline policy needed	Requires policy in place	Mr Arin Saha	April 2017
Discussion with Upper GI at HRI before referring to Leeds	Patients are now referred to upper GI if pancreatitis cause unknown	Mr Arin Saha	Complete, now referring
Cholecystectomy to be undertaken within 2 weeks	To use free theatre spaces for all Cholecystectomies	Mr Arin Saha	Complete, now using free space
Escalation to COG	Action plan to be escalated to COG	Carole Hallam	Complete
Anti-biotic prescribing not appropriate for pancreatitis patients. Need to wait for Amylase results to come back before decision making	Sepsis bundle protocol to be amended appropriately for Pancreatitis patients	Anu Rajgopal/Arin Saha	March 2017

Sentinel Stroke National Audit Programme, SSNAP, Annual Report for April 2015 - March 2016 data

Introduction:

This annual report is based on patients arriving at hospital (or having stroke onset as an inpatient) between 1 April 2015 – 31 March 2016 and patients who were discharged from inpatient care during the same period. The Clinical Effectiveness and Evaluation Unit in the Clinical Standards Department of the Royal College of Physicians first conducted the National Sentinel Stroke Audit (NSSA) in 1998 and subsequently a total of 8 rounds have been undertaken with 100% participation achieved since 2006. SSNAP combines the NSSA and the Stroke Improvement National Audit Programme (SINAP) which audited care in the first 72 hours after stroke. SSNAP is aiming to be the single source of stroke data for local teams, regional authorities and at a national level.

Aim: benchmark services regionally and nationally

- monitor progress against a background of organisational change to stroke services and more generally in the NHS
- support clinicians in identifying where improvements are needed, planning for and lobbying for change and celebrating success
- empower patients to ask searching questions

Summary of Findings

			National (teams meeting minimum criteria) 2015-16	Calderdale Royal Hospital 2015-16
B1.1: Average patient-centred case ascertainment	Patient centred	Both cohorts	90%+	90%+
B2.1: Case ascertainment for all patients seen by your team with a clock start between 1st April 2015 and 31st March 2016	Patient centred	72h cohort	90%+	90%+
B3.1: Case ascertainment for all patients seen by your team who were discharged from inpatient care between 1st April 2015 and 31st March 2016	Patient centred	Post-72h cohort	90%+	90%+

SSNAP Key Indicators

Standard targets are based on achieving optimum performance of Level A in SSNAP. For timings, the shorter the median time to intervention the better.

Category	Criteria	Std	CRH 2015-16	National 2015-16
Scanning	% patients scanned within 1 hour	**48% of all stroke patients**	**32.8%**	**47.5%**
Stroke Unit	% of patients directly admitted to stroke within 4 hours	**90%**	**61%**	**58.3%**
	% of patients who spent at least 90% of their stay on a stroke unit	**90%**	**82.8%**	**84.8%**
Thrombolysis	% of thrombolysed patients within 1 hour (meeting criteria)	**55%**	**57.9%**	**58.5%**
Specialist Assessments	% of patients who were given a swallow screen with 4 hours	**85%**	**70.8%**	**71.6%**
	% of patients assessed by a stroke consultant within 24 hours at CRH	**95%**	**79.6%**	**78.6%**
Occupational Therapy	Median % of days as an inpatient on which OT is received	**>70%**	**Median 56.3%**	**Median 61.1%**
	Median minutes per day on which OT is received	**>32 mins**	**41.9 mins**	**40 mins**
Physiotherapy	Median % of days as an inpatient on which PT is received	**>75%**	**Median 65.3%**	**Median 70.2%**
	Median minutes per day on which PT is received	**>32 mins**	**33.3 mins**	**35 mins**

Category	Criteria	Std	CRH 2015-16	National 2015-16
Speech & Language	Median % of days as an inpatient on which SALT is received	**>70%**	**Median 45.0%**	**Median 44.1%**
	Median minutes per day on which SALT is received	**>32 mins**	**32.5 mins**	**32.5 mins**
MDT working	% of applicable patients who were assessed by SALT within 72hr	**90%**	**76.4%**	**85%**
	The median time between clock start and being assessed by OT	**<12 hours**	**22:47 hrs**	**22:15 hrs**
	The median time between clock start and being assessed by PT	**<12 hours**	**21:21 hrs**	**21:25 hrs**
Standards by discharge	% of patients who have a continence plan drawn up within 3 weeks of clock start	**95%**	**79.4%**	**89.3%**
	% of patients at CRH screened for nutrition and seen by a dietitian by discharge	**95%**	**81.4%**	**79.2%**
Discharge process	% of applicable patients receiving JCP on discharge	**90%**	**71.6%**	**87.8%**
	% of patients discharged (alive) who are given a named person to contact after discharge	**95%**	**55.5%**	**90.9%**
	% of patients at CRH were supported by ESD	**40%**	**47.3%**	**32.9%**
	% of patients in AF who are discharged on (or with a plan to start) anticoagulants	**95%**	**100%**	**97%**

Audit Compliance
The 2015-2016 report shows a compliance banding of C, this was the same as the last two SSNAP reports. The compliance score for 2015-16 is 76.6% (compared to 78% last year and 76.5% in 2013-14. Next year should see a marked improvement in this area.

What changes in practice have been agreed?

Recommendations	Actions	Lead Person	Timescale
Improve door to needle time for thrombolysis	Take pre alert thrombolysis patients directly to CT.	Dr Anand Nair	Dec 2016
Improve consultant assessment time	Introduce stroke consultant of the week.	Dr Pratap S Rana	Dec 2016
Increase CT scans within 1 hour	Pilot with radiology to scan all stroke patients in hours.	Dr Anand Nair	Dec 2016
Improve SSNAP case ascertainment	Appoint a SSNAP data collection assistant.	Maureen Overton	Nov 2016
Reduce LOS	Pilot new ways of working on 7B (SRU) with the aim to reduce overall length of stay.	Dr Anand Nair	March 2016

British Thoracic Society, BTS, Childhood Asthma Audit 2016

Introduction:
The BTS Paediatric Asthma Audit has been on the list of national audits approved for inclusion in Department of Health Quality Accounts for England. Data is collected on every child with wheezing or asthma over 1 year of age admitted into participating hospitals for more than 4 hours. It benchmarks a unit's clinical performance in 5 domains (basic demographic information; initial hospital assessment; initial hospital treatment; discharge planning; and follow- up) against aggregated national data. Since November is generally a busy month for respiratory illness in children, the audits have provided a snapshot of the management of acutely wheezy children at a time when Paediatric units are busy.

Summary of Findings:
Identified all children <16 years who attended Calderdale Royal Hospital due to Asthma from 01 – 30th November 2015. Identify any readmissions from 01 November to 28th February 2016.

Gender distribution		
	CRH n=26	**National Data**
Female	34.62%	37.31%
Male	65.38%	62.69%
Age on admission		
	CRH n=25	**National Data**
2 to 4 yrs	3	1,306
5 to 12 yrs	20	2,720
Over 12 yrs	2	203
Length of Stay		
	CRH n=26	**National Data**
0 days	11	1,614
1 days	9	2,555
2 days	3	748
3 days	1	285
4 days	1	144
5 days	1	55

Number of admissions with wheezing/asthma in past year		
	CRH n=17	**National Data**
1 admissions	11	1,204
2 admissions	4	441
3 admissions	2	234
Was child readmitted within 3 months with further episode of wheezing/asthma		
	CRH n=26	National Data
Yes	4 (15.4%)	744 (13.4%)
No	22 (84.6%)	4,291 (77.4%)
No data recorded		510 (9.2%)
Are cigarette smokers in the child's home environment		
	CRH n=26	**National Data**
Yes	5 (19.2%)	999 (18%)
No	7 (26.9%)	2,112 (38.1%)
No data/not recorded	14 (53.8%)	2,434 (43.9%)
Treatment – B2 agonist, Ipratopium, Steroids, Oxygen treatment		
	CRH n=26	**National Data**
B2 agonist administered?	100%	98%
Ipratopium administered?	38%	51%
Steriods administered?	96%	76%
Oxygen administerd?	31%	40%
Treatment – IV Magnesium, IV Aminophylline, IV B2 agonist, Admitted to PICU		
	CRH n=26	**National Data**
IV Magnesium administered?	0%	6%
IV Aminophylline administered?	4%	3%
IV B2 Agonist administered?	0%	3%
Admitted to PICU/HDU	8%	4%
CXR done, Antibiotics given		
	CRH n=26	**National Data**
CXR done?	12%	24%
Antibiotics given?	37%	28%
Discharge Information		
	CRH n=26	**National Data**
Information eg leaflet	0%	47%
Devise technique assessed	35%	42%
Written asthma plan given	81%	56%
Given a peak flow meter	4%	2%
Store of steroids given	19%	12%

National Data Comparisons

Better than National

- Written advice plan (91% compared to 56% nationally)
- Avoiding CXR (76% compared to 62% nationally)

Worse than National

- Leaflets (0% compared to 53% nationally)
- Giving antibiotics (37% compared to 28% nationally)
- Checking device technique (35% compared to 42% nationally)

Comparisons to 2013 Audit

- Fewer CXR requests: 12% compared to 37% (aim 10%)
- Antibiotic usage up from 8% to 37%
- Giving asthma plans improved from 63% to 81%
- Giving leaflets have worsened from 53% to 0%
- Checking technique worsened from 63% to 35%

Advised to attend GP poor both years (3.8% compared to national 23.9%)

What changes in practice have been agreed?

Recommendations	Actions	Lead Person	Timescale
1. To inform all nursing staff that clear documentation of asthma care is needed and is laid out in an organised system (i.e. prompts) on the CCNT copy of the Asthma Management Plan. 2. To ensure that staff know where the Asthma UK leaflets are kept on the ward. (Shelagh orders additional copies so that there are always plenty of leaflets available) 3. To document inhaler technique checking clearly in the ongoing episode of care and also on the Education Checklist itself. Deborah Naylor, Sister to suggest that nursing staff do 5 actuations of salbutamol to demonstrate the technique required and then encourage the parent/ carer to administer the following 5 actuations.	Dr Kumar is on AL 5-16 September and Deborah Naylor, Sister plans to use her clinic hours to be on ward 3 to promote the use of the plan and encourage staff to ask any questions that they may have on that day or by email. BTS audit is on the agenda for the next Sisters' meeting on 14.09.16 to discuss and ensure we are leading by example in clinical practice.	Deborah Naylor, Sister	October 2016 Complete
4. Antibiotic usage up from 8% to 37%. Dr Garside, Cons, to conduct snapshot audit to check antibiotic usage.	8 patients with acute asthma admitted in October 2016 were audited. 1 in 8 (12.5%) were prescribed antibiotics, an improvement on 37% in 2015. Re-audit in 2017.	Dr J Garside, Consultant	October 2016 Complete

Other National Clinical Audits the Trust has participated in during 2016/17:

- UK National Bariatric Surgery Registry
- Breast & Cosmetic Implant Registry
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Nephrectomy Surgery (BAUS)
- PCNL (BAUS)
- Invasive cytology
- National Cardiac Rehab audit
- National review of adult asthma deaths – year 5

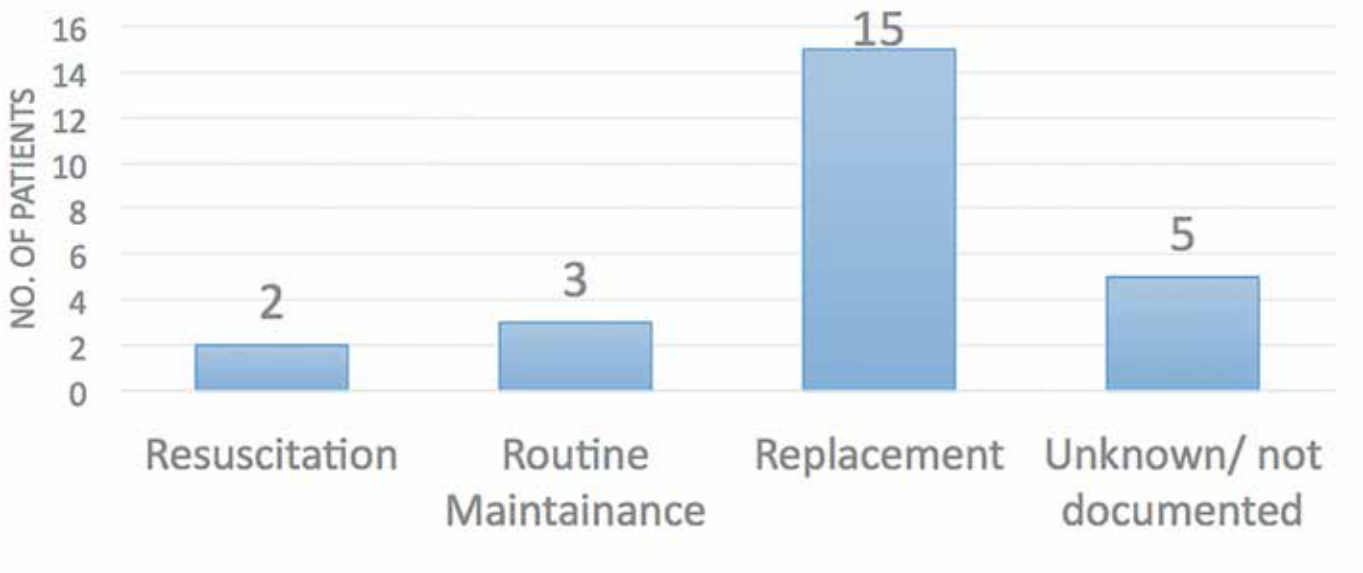
- SAMBA 2016 (Day in the life of an AMU)
- BSUG Stress Incontinence database
- National Completed Acute Diverticulitis Audit (CADS)
- OAKS (Outcomes after Kidney Injury)
- National audit of Nutritional Screening (BAPEN)
- GEMSS Multiple Sclerosis National Survey 2016
- National Audit of Small Bowel Obstruction (NASBO)
- Potential Donor Audit
- Epistaxis Audit

The reports of 89 local clinical audits were reviewed by the provider in 2016/17 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Intravenous Fluid Therapy Practice at CHFT
There were no Trust Guidelines available regarding: Intravenous Fluid Therapy, this audit will help assess the basic practice in the trust and help develop Trust IV Fluid guidelines in line with the NICE recommendations
Objectives:

- Intravenous Fluid Guideline Awareness among staff at CHFT
- Current IV Fluid prescription practice at CHFT
- Develop Trust Guidelines for Intravenous Fluid Therapy

Summary of findings
Indications for IV fluid



Assessments documented

Fluid used
- Normal saline 64%
- 5% dextrose 25%
- Ability to eat and drink documented 24%
- Management plan documented 5

Good points
– Daily U&E
– Reason for fluids
– Fluid balance

Needs improvement
– Volume status
– Monitoring weight

Summary of findings (2nd Audit: Roll out in other areas)
Good points
– Daily U&E (77%)
– Daily review (70%)

Needs improvement
– Documenting Na/K (~50%)
– Documenting chloride (0%)
  – Not reported by lab
– Fluid balance (55%)
– Delay in starting fluids
  – 10% >120 minutes
  – 40% no timings in notes

Action plan

Recommendation	Action Require	Person Responsible	Deadline
Establish Trust IV fluid lead	Appoint appropriate clinician	Dr Faisal Ehsan	Complete
Establish IV fluid working group	Updated guidance based on NICE 5 R's Created and ready to be launched. AS A SUBSET OF THE AKI WORKING GROUP AT THE MOMENT	Dr. Faisal Ehsan	Complete
Changes to IV fluid prescription on EPR	Link to fluid balance chart Link to electrolytes on ICE Record time of fluid prescription Prescribing as ml/hr	Dr. Faisal Ehsan Mr W. Ainslie Miss P. Daynes	April 2017
Education gained through E-Learning	Fluid prescribing E-Learning Module	Incorporate into junior doctor induction for next round	April 2017
Plan to re-audit with EPR launch	Re-audit in Jan 2017	Dr. Faisal Ehsan Dr. Andy Hardy Dr. Suneeta Teckchandani	April 2017

What potential clinical benefits will result from this audit?

- Implementation of NICE Guidelines trust wide
- Staff training and development
- Clinical Governance

Audit of the use of Propofol as premedication for neonatal intubation – July 2016

Sedation and analgesia for non-emergency intubations in neonates is preferable to intubation without sedation. A sedated baby is easier to intubate, which decreases the failure rate of intubation and the duration of the procedure, as well as reducing the risk of upper airway trauma. A sedated baby will also exhibit less physiological reactions to intubation including changes in heart rate, blood pressure and oxygen saturations, thus avoiding further instability in an already unwell child. Ideally, premedication should provide analgesia, sedation and muscle relaxation but drugs used in different units to achieve this vary and there is no universally accepted strategy. Pre-intubation drugs should be easy to prepare to avoid dosing mistakes and delays.

Propofol is a fairly new agent being used in the neonatal population for premedication for procedures. It acts as a hypnotic and muscle relaxant and can therefore be used as a single pre-intubation agent. Efficacy and safety of Propofol have recently been demonstrated in a randomised controlled trial.

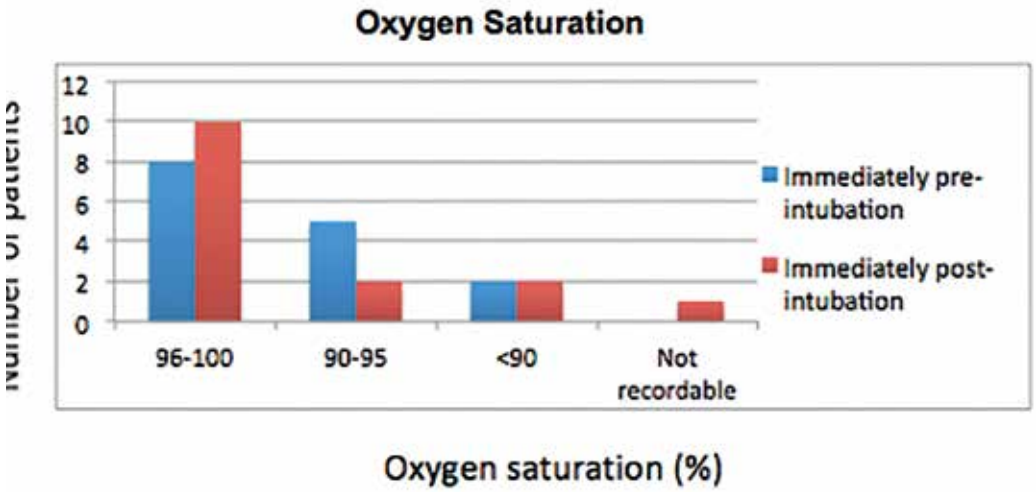
The local NNU previously used Atropine, Fentanyl and Suxamethonium as first line pre-intubation drugs. This regime was mostly successful although some babies needed ventilation for a period of time following drug administration due to prolonged action of drugs rather than due to the baby's illness. Moreover, it was time-consuming to prepare three different drugs and there was some scope for error; a recent incident resulted in under-dosing a baby with pre-intubation drugs but there is a significant risk of overdosing as well. A recent SIM training session also demonstrated that it takes two people over 10 minutes to prepare these drugs, potentially resulting in a significant delay in the intubation and taking two people away from potentially more important tasks.

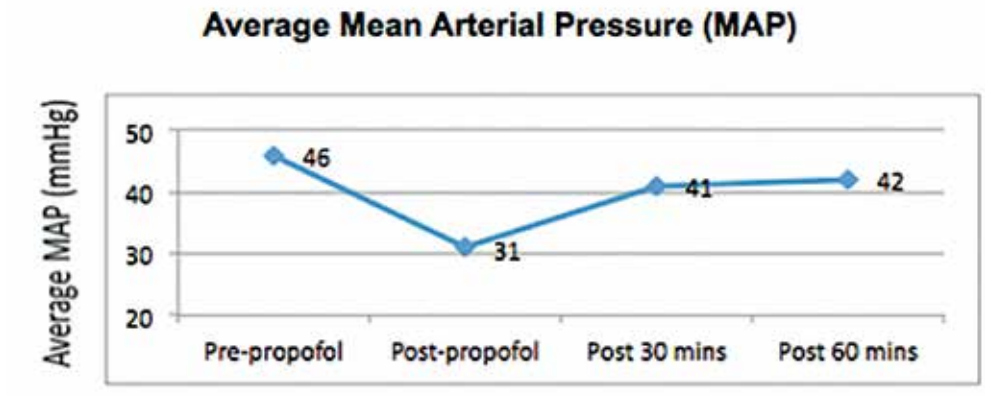
There is no national guidance on the use of pre-intubation drugs for neonates and different units use different drug combinations. Propofol is used in older patients and Newcastle and Leeds have started successfully to use it on their units. Leeds has audited their use of Propofol since introduction and no significant problems have been identified although Propofol can result in a transient decrease in blood pressure. The clinical significance of this was unclear.

CHFT introduced guidelines in July 2015 - *Sedation for non-emergency intubation on NNU CRH*

Aims/Objectives:
To assess current local practice, specifically
- Use of Propofol according to current local guidelines
- Time taken to prepare and administer drug(s)
- Time taken to achieve successful intubation
- Whether further pre-medications are required
- Adverse effects noted from use of pre-intubation drugs

Summary of Findings:
- 15 babies received Propofol between November 2015 –June 2016
- 10/15 (67%) were planned 1st intubations
- 3/15 babies required physical restraint
- 6/15 babies intubated on 1st attempt, 7 on 2nd, 1 on 3rd and 1 on 5th
- 8/15 babies required repeated doses of medication
- 2/15 babies required 2nd line drugs – 1 for hiccoughs, 1 indication not known
- Time to successful intubation ranged from1 min to 20 mins





Adverse effects

- One incident – same baby:
  - Laryngospasm
  - 5 attempts at intubation
  - 20 mins taken to successful intubation
  - O2 Sats immediately after intubation 0%

Limitations

- No previous local audit to compare figures prior to introduction of Propofol
- Relatively small patient number
- Some data not recorded on proforma
- Clinical relevance of post-Propofol hypotension – did it require treatment?

Conclusions

- Evidence from RCT and LTHT audit in favour of Propofol; this audit also supports the use of Propofol
- Advantages of Propofol compared to morphine/atropine/suxamethonium:
  - Easier to prepare (single agent)
  - Shorter time to successful intubation
  - Reduced number of intubation attempts
  - Less hypoxia during intubation
  - Less airway trauma
  - Faster recovery
- Disadvantages
  - Known side effect of hypotension
  - Repeated doses of Propofol needed in several cases

Contra-indications: duct-dependent cardiac lesions

Discussion at Paediatric Governance meeting

- Reminder to be aware of babies with duct defects & not to give them Propofol. It is not always clear cut how to identify them
- Suggestion to have Suxamethonium standing by in case of laryngospasm – query whether add to guidelines
- As many babies in the audit needed a second dose, it was mentioned that all equipment be prepared before the intubation as Propofol doesn't last long. It may be necessary to increase the dose given.
- It was agreed to continue the use of Propofol and re-audit with larger numbers

What changes in practice have been agreed?

Recommendation	Action	Lead Person	Timescale
Continue use of Propofol as first-line premedication for neonatal intubation in this Trust	Continue current practice	Karin Schwarz	Ongoing Complete
Further data collection needed – larger patient numbers	Continue to audit until gathered 12 months data	Karin Schwarz Jacky Meehan	Nov 2016
Continue to report any adverse effects thought to be associated with Propofol	Will be picked up through the audit	Karin Schwarz	Ongoing Complete
Further studies required ? Routinely add analgesic agent ? Augment initial dose – safety studies needed	To be discussed further at neonatal forum	Karin Schwarz	August 2016

NHS

Calderdale and Huddersfield

NHS Foundation Trust

Accounts

2016/17

compassionate care

These accounts, for the year ended 31 March 2017, 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, are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006;

Owen Williams (Chief Executive)
Date: 23rd May 2017

Statement of Comprehensive Income				
		2016/17		**2015/16**
	Note	**£000**		**£000**
Operating income from patient care activities	3	330,970		318,383
*Other operating income	4	44,281		31,799
Total operating income from continuing operations		**375,251**		**350,182**
Operating expenses	5, 7	(374,838)		(366,740)
****Operating surplus/(deficit) from continuing operations**		**413**		**(16,558)**
Finance income	10	34		59
Finance expenses	11	(11,937)		(11,346)
PDC dividends payable		(2,488)		(3,042)
Net finance costs		**(14,391)**		**(14,329)**
Gains/(losses) of disposal of non-current assets	12	(236)		(23)
Share of profit of associates/joint arrangements	19	423		1,113
Corporation tax expense	13	-		-
Surplus/(deficit) for the year from continuing operations		**(13,791)**		**(29,797)**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations	14	-		-
Surplus/(deficit) for the year		**(13,791)**		**(29,797)**
Other comprehensive income				
Will not be reclassified to income and expenditure:				
Impairments	6	(5,754)		(12,276)
Revaluations	18	8,523		12,373
Share of comprehensive income from associates and joint ventures	19	-		-
Other recognised gains and losses		-		-
Other reserve movements		-		-
May be reclassified to income and expenditure when certain conditions are met:				
Fair value gains/(losses) on available-for-sale financial investments		-		-
Recycling gains/(losses) on available-for-sale financial investments	10	-		-
Total comprehensive income/(expense) for the period		**(11,022)**		**(29,700)**
* Other operating income includes £12.654m of Sustainability and Transformation Fund income, this support was not available in 15/16				
** The surplus deficit for 16/17 includes £1.2m reversal of impairments, for 15/16 this was £8.817m impairment.				

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	**£000**	**£000**	**£000**
Taxpayers' and others' equity at 1 April 2016 - brought forward	115,720	36,121	(54,998)	**96,843**
Surplus/(deficit) for the year	-	-	(13,790)	**(13,790)**
Other transfers between reserves	-	(557)	557	**-**
Impairments	-	(5,754)	-	**(5,754)**
Revaluations	-	8,523	-	**8,523**
Transfer to retained earnings on disposal of assets	-	(869)	869	**-**
Public dividend capital received	470	-	-	**470**
Taxpayers' and others' equity at 31 March 2017	**116,190**	**37,464**	**(67,362)**	**86,292**

Statement of Changes in Equity for the year ended 31 March 2016

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	**£000**
Taxpayers' and others' equity at 1 April 2015 - brought forward	**115,687**	**36,627**	**(25,804)**	**126,510**
Surplus/(deficit) for the year	-	-	(29,797)	**(29,797)**
Other transfers between reserves	-	(596)	596	**-**
Impairments	-	(12,276)	-	**(12,276)**
Revaluations	-	12,373	-	**12,373**
Transfer to retained earnings on disposal of assets	-	(7)	7	**-**
Public dividend capital received	33	-	-	**33**
Taxpayers' and others' equity at 31 March 2016	**115,720**	**36,121**	**(54,998)**	**96,843**

Statement of Financial Position

	Note	31 March 2017 £000		31 March 2016 £000
Non-current assets				
Intangible assets	15	1,866		1,132
Property, plant and equipment	16	234,272		217,015
Investments in associates (and joint ventures)	19	2,889		2,466
Trade and other receivables	22	3,130		2,954
Total non-current assets		**242,157**		**223,567**
Current assets				
Inventories	21	6,724		6,972
Trade and other receivables	22	19,298		16,513
Non-current assets for sale and assets in disposal groups	23	4,215		5,783
Cash and cash equivalents	24	1,941		1,938
Total current assets		**32,178**		**31,206**
Current liabilities				
Trade and other payables	25	(41,536)		(39,576)
Other liabilities	26	(1,552)		(1,235)
Borrowings	27	(4,053)		(3,118)
Provisions	28	(1,878)		(2,236)
Total current liabilities		**(49,019)**		**(46,165)**
Total assets less current liabilities		**225,316**		**208,608**
Non-current liabilities				
Trade and other payables	25	(164)		(245)
Other liabilities	26	(1,339)		(1,353)
Borrowings	27	(135,214)		(107,726)
Provisions	28	(2,306)		(2,441)
Total non-current liabilities		**(139,023)**		**(111,765)**
Total assets employed		**86,292**		**96,843**
Financed by				
Public dividend capital		116,190		115,720
Revaluation reserve		37,464		36,121
Available for sale investments reserve		-		-
Other reserves		-		-
Merger reserve		-		-
Income and expenditure reserve		(67,362)		(54,998)
Total taxpayers' equity		**86,292**		**96,843**

The Financial Statements were approved by the Board on 25th May 2017 and signed on its behalf by:

Name Owen Williams
Position Chief Executive
Date **25 May 2017**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows

		2016/17		2015/16
	Note	**£000**		**£000**
Cash flows from operating activities				
Operating surplus/(deficit)		413		(16,557)
Non-cash income and expense:				
Depreciation and amortisation	5.1	10,074		10,439
Net impairments	6	(1,204)		8,817
Income recognised in respect of capital donations	4	(66)		(10)
Amortisation of PFI deferred credit	4	-		-
Non-cash movements in on-SoFP pension liability		-		-
(Increase)/decrease in receivables and other assets		(3,222)		(2,770)
(Increase)/decrease in inventories		248		(999)
Increase/(decrease) in payables and other liabilities		(3,714)		3,567
Increase/(decrease) in provisions		(528)		(1,178)
Tax (paid)/received		-		-
Operating cash flows movement of discontinued operations		-		-
Other movements in operating cash flows		8		(9)
Net cash generated from/(used in) operating activities		**2,009**		**1,300**
Cash flows from investing activities				
Interest received		34		59
Purchase and sale of financial assets		-		-
Purchase of intangible assets		(998)		(203)
Sales of intangible assets		-		-
Purchase of property, plant, equipment and investment property		(17,200)		(19,977)
Sales of property, plant, equipment and investment property		1,348		14
Receipt of cash donations to purchase capital assets		66		10
Prepayment of PFI capital contributions		-		-
Investing cash flows of discontinued operations		-		-
Net cash generated from/(used in) investing activities		**(16,750)**		**(20,097)**
Cash flows from financing activities				
Public dividend capital received		470		33
Public dividend capital repaid		-		-
Movement on loans from the Department of Health		29,827		22,900
Movement on other loans		-		-
Capital element of finance lease rental payments		-		-
Capital element of PFI, LIFT and other service concession payments		(1,405)		(1,496)
Interest paid on finance lease liabilities		-		-
Interest paid on PFI, LIFT and other service concession obligations		(10,850)		(10,896)
Other capital receipts		-		-
Other interest paid		(944)		(306)
PDC dividend paid		(2,354)		(3,197)
Financing cash flows of discontinued operations		-		-
Cash flows from (used in) other financing activities		-		-
Net cash generated from/(used in) financing activities		**14,744**		**7,038**
Increase/(decrease) in cash and cash equivalents		**3**		**(11,759)**
Cash and cash equivalents at 1 April		**1,938**		**13,697**
Cash and cash equivalents at 31 March	**24**	**1,941**		**1,938**

Notes to the Accounts

Note 1 Accounting policies and other information

Basis of preparation
NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. NHS Improvement has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Department of Health Group Accounting Manual (DH GAM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the DH GAM 2016/17 issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM 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.

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.

Going concern
These accounts have been prepared on a going concern basis.

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

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

The Foundation Trust has assessed various sources of information in order to assess whether it is appropriate to prepare the accounts on a going concern basis. These include both internal and external reporting, the Foundation Trust's long term financial plan, audit reports and dialogue with NHS Improvement.

The Foundation Trust has closed the year with a cash balance of £1.941m and net assets of £86m.
However, given the challenge within the financial plans for 2017/18 further areas require consideration to be able to demonstrate that the Foundation Trust is a going concern.

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

- The unaudited year-end financial position of £14.99m deficit (excluding exceptional items as described in note to the SOCI) was in line with the planned deficit of £16.1m. Whilst still a deficit position; this secures a level of confidence from NHS Improvement in the Foundation Trust's ability to deliver plans.
- The Foundation Trust closed the year with £1.94m of cash but cannot sustain the planned deficit position within 2017/18 without the requirements of external cash support. As such, the Foundation Trust has been in communication with NHS Improvement to arrange for loan facilities to enable the Foundation Trust to operate throughout 2017/18. With this borrowing in place, the Foundation Trust will be able to meet its liabilities.
- The Commissioners continue to commission services from the Foundation Trust and contracts for 2017/18 with commissioners have been agreed and were signed in February 2017. This leads to regular monthly transfers of fixed levels of cash based on contracted values for 2017/18. This incoming cash along with the loan facility will allow the Trust to meet all its obligations and liabilities.
- From Internal Audit reports completed in 2016/17 there have been no other indications of significant financial risk or weaknesses in financial risk management
- Throughout 2016/17 the Foundation Trust has continued to work closely with local partners to develop a long term strategy and consult with the public on future plans. The Foundation Trust is continuing to work upon service transformation plans aided by reconfiguration to deliver a sustainable long term future. This strategy has been supported by regulators.
- In 2016/17 the CIP challenge of £14m was exceeded by £0.98m. A project management office is in place and the PMO methodology ensures that the CIP plans for 2017/18 are robust and oversees delivery. 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. Delivery of the 2017/18 financial plan requires an efficiency saving of £20m. This is not yet fully identified.
- In conclusion the Foundation Trust does not have any evidence to suggest that the going concern basis is not appropriate. There is a reasonable expectation that Calderdale and Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.

Note 1.1 Interests in other entities

Joint ventures
Joint ventures are arrangements in which the trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Subsidiaries
Calderdale & Huddersfield NHS Foundation Trust is the corporate trustee to Calderdale & Huddersfield NHS Foundation Trust charitable fund. The foundation trust has assessed it's relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The Foundation Trust has assessed that the values involved are not of material nature and the Trust Board has approved and agreed not to consolidated the Charitable Funds.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.
Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.3 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. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. 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.

Note 1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.5 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
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, 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 year.
A full valuation was last done in March 2015.
A desktop revaluation exercise was done of all property as at 31 March 2017.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyor (RICS) Appraisal and Valuation Manual.
Specialised operational property is valued using the HM Treasury standard approach of depreciated replacement cost valuation based on modern equivalent assets.

Non-specialised operational owner-occupied property is valued at existing use value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

Equipment is carried at depreciated historical cost as these are considered to be a reasonable proxy for fair value

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

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

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

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

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

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed.
Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised.

Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

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

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

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

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

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

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. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

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

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

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

Useful Economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life	Max life
	Years	Years
Land	-	-
Buildings, excluding dwellings	15	80
Dwellings	15	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	5	8
Furniture & fittings	5	10

Finance-leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.6 Intangible assets

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

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

Expenditure on research is not capitalised.

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

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

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

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

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

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

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life	Max life
	Years	Years
Intangible assets - internally generated		
Information technology	5	5
Development expenditure	-	-
Other	-	-
Intangible assets - purchased		
Software	5	8
Licences & trademarks	-	-
Patents	-	-
Other	-	-
Goodwill	-	-

Note 1.7 Revenue government and other grants

Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. The cost valuation is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

Note 1.9 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 above/below.

All other financial assets and financial liabilities are recognised when the Foundation Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation 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 Foundation Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts 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 Foundation Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision

Note 1.10 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the 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 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.

Note 1.11 Provisions

The 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 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 Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Foundation Trust is disclosed at note 28.1 but is not recognised in the Foundation Trust's accounts.

Non-clinical risk pooling
The 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.

Note 1.12 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 29 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 29, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.13 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 Foundation 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 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 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 (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.14 Value added tax

Most of the activities of the 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.

Note 1.15 Corporation tax

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

Note 1.16 Foreign exchange

The functional and presentational currencies of the Foundation 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 Foundation Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.
Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items."

Note 1.17 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the 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 FReM.

Note 1.18 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 Foundation 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 accrual basis with the exception of provisions for future losses.

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. The application of the Standards as revised would not have a material impact on the accounts for 2016-17, were they applied in that year:
IFRS 9 Financial Instruments
IFRS 15 Revenue from Contracts with Customers
IFRS 16 Leases
IFRIC 22 Foreign Currency Transactions and Advance Consideration

Note 1.21 Critical accounting estimates and judgements
In the application of the Foundation 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.
The management has had to make no critical judgements, apart from those involving estimations (see below) in the process of applying the Foundation Trust's accounting policies.

Note 1.21.1 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 Foundation Trust's land and buildings is subject to significant estimation uncertainty, since it derives from estimates provided by the Foundation 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 Foundation Trust's estate.

Note 1.21.2 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 Foundation 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 Foundation 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 Foundation 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.

Note 2 Operating Segments

The Foundation Trust's core activities fall under the remit of the Chief Operating Decision Maker ("CODM") as defined by IFRS 8 'Operating Segments', which has been determined to be the Foundatrion Trust Board which includes senior professional non-executive directors. These core activities are primarily the provision of specialist NHS healthcare, the income for which is received through contracts with commissioners. The planned level of activity is agreed with our main commissioners for the year, and are listed in the related party disclosure (see Note 37.1)

Healthcare

The large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore a segment of 'Healthcare' is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board. The Trust Board 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.

	Healthcare	
	2016/17	**2015/16**
	£000	**£000**
Income	375,251	350,182
Surplus / (Deficit)	(13,791)	(29,797)
Net Assets	**86,292**	**96,843**

Note 3 Operating income from patient care activities			
Note 3.1 Income from patient care activities (by nature)			
	2016/17		**2015/16**
	£000		**£000**
Acute services			
Elective income	49,190		45,472
Non elective income	89,725		84,475
Outpatient income	45,922		40,806
A & E income	16,806		16,076
*Other NHS clinical income	118,465		126,528
All services			
Private patient income	474		503
Other clinical income	10,388		4,523
Total income from activities	**330,970**		**318,383**
* Other NHS Clinical Income, includes income for NHS Tariff income including income for, Direct access £6.8m and maternity pathways £10.8m, it also includes Non Tariff income including income for, block contracts of £30.6m for various services, including community services, income for critical care £8.3m, pass through cost for high cost drugs and devices £24.8m, rehabilitation £5.1m, diagnostic tests and imaging £7.4m, CQUIN £6.9m, local priced outpatients £6.8m and other clinical income of £10.9m.			
Note 3.2 Income from patient care activities (by source)			
Income from patient care activities received from:	**2016/17**		**2015/16**
	£000		**£000**
CCGs and NHS England	318,938		308,090
Local authorities	6,057		4,509
Department of Health	-		-
Other NHS foundation trusts	513		260
NHS trusts	699		500
NHS other	0		1
Non-NHS: private patients	474		503
Non-NHS: overseas patients (chargeable to patient)	118		110
NHS injury scheme (was RTA)	1,910		1,769
Non NHS: other	2,261		2,641
Additional income for delivery of healthcare services	-		-
Total income from activities	**330,970**		**318,383**
Of which:			
Related to continuing operations	330,970		318,383
Related to discontinued operations	-		-

Note 3.3 Overseas visitors (relating to patients charged directly by the NHS foundation trust)

	2016/17		2015/16
	£000		£000
Income recognised this year	118		110
Outstanding Debt as at 31st March	216		170
Cash payments received in-year	26		35
Amounts added to provision for impairment of receivables	120		131
Amounts written off in-year	11		48

Note 4 Other operating income

	2016/17		2015/16
	£000		£000
Research and development	1,074		992
Education and training	8,790		8,719
Receipt of capital grants and donations	66		15
Charitable and other contributions to expenditure	425		405
Non-patient care services to other bodies *	9,028		9,646
Support from the Department of Health for mergers	-		-
Sustainability and Transformation Fund income **	12,654		-
Rental revenue from operating leases	58		67
Rental revenue from finance leases	-		-
Amortisation of PFI deferred credits	-		-
Income in respect of staff costs where accounted on gross basis	-		-
Other income ***	12,186		11,955
Total other operating income	**44,281**		**31,799**
Of which:			
Related to continuing operations	44,281		31,799
Related to discontinued operations	-		-

* Non-patient care services to other bodies includes £5.5m income for The Health Informatics Service, for IT services provided to other bodies and £3.1m income for Estates and Facilities for recharges to other bodies for use of buildings, including £3m to SWYPFT for use of the Dales unit.
** The Sustainability and Transformation fund Income of £12.654m, was a new source of support funding made available in 16/17.
*** other operating income of £12.186m includes £7.3m sales of manufactured pharmaceutical products, £2.7m car parking income, £0.5m property rental income, £0.4m catering income (In 2015/16 the comparative figures were £6.8m for sale of manufactured in pharmaceutical products, £2.0m car parking income, £0.5m property rental income, £0.4m catering income).

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2016/17		2015/16
	£000		£000
Income from services designated (or grandfathered) as commissioner requested services	324,121		313,834
Income from services not designated as commissioner requested services	6,849		4,449
Total	**330,970**		**318,283**

Note 4.2 Profits and losses on disposal of property, plant and equipment

In December 2016, the Trust sold The Princess Royal Health Centre to LOCALA; prior to the sale the Trust provided Children's Services from the Princess Royal site. To aid links with other services provided by LOCALA, the Trust continues to provide some services from Princess Royal and has a rental agreement with LOCALA for the space used.
The Princess Royal net book value was £1.5m whilst the site was sold for £1.215m creating a loss in disposal of £0.285m, including cost of sales.

Note 5.1 Operating expenses			
	2016/17		**2015/16**
	£000		**£000**
* Services from NHS foundation trusts	(8)		39
Services from NHS trusts	1,894		1,732
Services from CCGs and NHS England	39		39
Services from other NHS bodies	3		-
Purchase of healthcare from non NHS bodies	818		807
Purchase of social care	-		-
Employee expenses - executive directors	1,180		990
Remuneration of non-executive directors	163		157
Employee expenses - staff	239,728		226,247
Supplies and services - clinical	31,170		28,917
Supplies and services - general	3,259		2,608
Establishment	4,394		4,515
Research and development	18		14
Transport	466		344
Premises	26,884		26,403
Increase/(decrease) in provision for impairment of receivables	76		577
Increase/(decrease) in other provisions	(211)		1,146
Change in provisions discount rate(s)	164		-
Inventories written down	-		-
Drug costs	32,916		32,274
Rentals under operating leases	4,548		4,787
Depreciation on property, plant and equipment	9,810		10,127
Amortisation on intangible assets	264		312
Net impairments	(1,204)		8,817
Audit fees payable to the external auditor			
audit services- statutory audit	55		82
other auditor remuneration (external auditor only)	12		12
Clinical negligence	15,493		11,308
Legal fees	149		181
Consultancy costs	61		2,729
Internal audit costs	182		-
Training, courses and conferences	727		809
Patient travel	22		21
Car parking & security	-		-
Redundancy	171		97
Early retirements	-		-
Hospitality	18		2
Publishing	-		-
Insurance	-		-
Other services, e.g. external payroll	-		-
Grossing up consortium arrangements	-		-
Losses, ex gratia & special payments	6		59
Other	1,571		588
Total	**374,838**		**366,740**
Of which:			
Related to continuing operations	374,838		366,740
Related to discontinued operations	-		-
* The Credit balance on expenditure for Services from NHS Foundation Trusts is due to credits in relation to prior year expenditure			

Note 5.2 Other auditor remuneration			
	2016/17		**2015/16**
	£000		**£000**
Other auditor remuneration paid to the external auditor:			
1. Audit of accounts of any associate of the trust	-		-
2. Audit-related assurance services	12		12
3. Taxation compliance services	-		-
4. All taxation advisory services not falling within item 3 above	-		-
5. Internal audit services	-		-
6. All assurance services not falling within items 1 to 5	-		-
7. Corporate finance transaction services not falling within items 1 to 6 above	-		-
8. Other non-audit services not falling within items 2 to 7 above	-		-
Total	**12**		**12**

Note 5.3 Limitation on auditor's liability
The limitation on auditors' liability for external audit work is £1m (2015/16: £1m).

Note 6 Impairment of assets			
	2016/17		**2015/16**
	£000		**£000**
Net impairments charged to operating surplus / deficit resulting from:			
Loss or damage from normal operations	-		-
Over specification of assets	-		-
Abandonment of assets in course of construction	-		-
Unforeseen obsolescence	-		-
Loss as a result of catastrophe	-		-
Changes in market price	(1,204)		8,817
Other	-		-
Total net impairments charged to operating surplus / deficit	**(1,204)**		**8,817**
Impairments charged to the revaluation reserve	5,754		12,276
Total net impairments	**4,550**		**21,093**
All impairments and reversal of impairments charged to operating costs and the revaluation reserve are due to changes in market values of building assets.			

Note 7 Employee benefits			
	2016/17		**2015/16**
	Total		**Total**
	£000		**£000**
Salaries and wages	180,742		175,496
Social security costs	16,594		12,497
Employer's contributions to NHS pensions	22,087		21,336
Pension cost - other	-		-
Other post employment benefits	-		-
Other employment benefits	-		-
Termination benefits	-		-
Temporary staff (including agency)	23,439		19,861
Total gross staff costs	**242,862**		**229,190**
Recoveries in respect of seconded staff	-		-
Total staff costs	**242,862**		**229,190**
Of which			
Costs capitalised as part of assets	1,954		1,953

Note 7.1 Retirements due to ill-health

During 2016/17 there were 11 early retirements from the trust agreed on the grounds of ill-health (9 in the year ended 31 March 2016). The estimated additional pension liabilities of these ill-health retirements is £735k (£516k in 2015/16). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:
a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

Note 9 Operating leases

Note 9.1 Calderdale & Huddersfield NHS Foundation Trust as a lessor
This note discloses income generated in operating lease agreements where Calderdale & Huddersfield NHS Foundation Trust is the lessor.
The lease revenue is for property leased to other organisations

	2016/17		2015/16
	£000		£000
Operating lease revenue			
Minimum lease receipts	52		60
Contingent rent	6		7
Other	-		-
Total	**58**		**67**
	31 March 2017		**31 March 2016**
	£000		**£000**
Future minimum lease receipts due:			
- not later than one year;	43		43
- later than one year and not later than five years;	32		58
- later than five years.	8		18
Total	**83**		**119**

Note 9.2 Calderdale & Huddersfield NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Calderdale & Huddersfield NHS Foundation Trust FT is the lessee.

	2016/17		2015/16
	£000		£000
Operating lease expense			
Minimum lease payments	4,558		4,805
Contingent rents	-		-
Less sublease payments received	(10)		(18)
Total	**4,548**		**4,787**
Of the operating lease expenditure £1.7m is for the leasing of buildings, £2.29m is for the leasing of plant and machinery			
	31 March 2017		**31 March 2016**
	£000		**£000**
Future minimum lease payments due:			
- not later than one year;	3,254		3,455
- later than one year and not later than five years;	9,023		9,780
- later than five years.	19,727		21,073
Total	**32,004**		**34,308**
Future minimum sublease payments to be received	-		-

Note 10 Finance income

Finance income represents interest received on assets and investments in the period.

	2016/17		2015/16
	£000		£000
Interest on bank accounts	34		59
Interest on loans and receivables	-		-
Interest on impaired financial assets	-		-
Interest on available for sale financial assets	-		-
Interest on held-to-maturity financial assets	-		-
Fair value gains / (losses) on other financial assets held at fair value through the income and expenditure	-		-
Recycling of gains / (losses) on available for sale financial instruments	-		-
Other	-		-
Total	34		59

Note 11.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2016/17		2015/16
	£000		£000
Interest expense:			
Loans from the Department of Health	1,051		391
Commercial loans	-		-
Overdrafts	-		-
Finance leases	-		-
Interest on late payment of commercial debt	-		-
Other	-		-
Main finance costs on PFI and LIFT schemes obligations	6,715		6,843
Contingent finance costs on PFI and LIFT scheme obligations	4,135		4,053
Total interest expense	**11,901**		**11,287**
Other finance costs	-		-
Unwinding of Discounts	36		59
Total	**11,937**		**11,346**

Note 11.2 The late payment of commercial debts (interest) Act 1998

The Trust incurred costs of £336 during 16/17 (Nil 15/16) arising from claims made under this legislation

Note 12 Gains/losses on disposal/derecognition of non-current assets

	2016/17		2015/16
	£000		£000
Profit on disposal of non-current assets	-		-
Loss on disposal of non-current assets	(236)		(23)
Net profit/(loss) on disposal of non-current assets	**(236)**		**(23)**

The Foundation Trust disposed of The Princess Royal Health Centre which had a net book value (NBV) of £1.5m and the Trust received sale proceeds of £1.215m, the Foundation Trust incurred costs of sale of £12k resulting in a loss on disposal of £297k. The sale of 38 Acre Street also took place, it had NBV of £67k and sale proceeds of £124k were received , giving a profit on disposal of £57k; there was also a small profit on disposal of £4k on sale of equipment.

Note 13 Corporation tax

The Trust has assessed that it is not liable for Corporation tax in 2016/17 or 2015/16.

Note 14 Discontinued operations

The Trust had no discontinued operations to disclose in 2016/17 or 2015/16.

Note 15.1 Intangible assets - 2016/17

	Software licences	Internally generated information technology	Total
	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**636**	**2,109**	**2,745**
Valuation/gross cost at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	-	-	-
Additions	-	998	**998**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Gross cost at 31 March 2017	**636**	**3,107**	**3,743**
Amortisation at 1 April 2016 - brought forward	**593**	**1,020**	**1,613**
Amortisation at start of period for new FTs	-	-	**-**
Transfers by absorption	-	-	**-**
Provided during the year	39	225	**264**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Amortisation at 31 March 2017	**632**	**1,245**	**1,877**
Net book value at 31 March 2017	**4**	**1,862**	**1,866**
Net book value at 1 April 2016	**43**	**1,089**	**1,132**

Note 15.2 Intangible assets - 2015/16			
	Software licences	**Internally generated information technology**	**Total**
	£000	**£000**	**£000**
Valuation/gross cost at 1 April 2015 - as previously stated	**636**	**1,906**	**2,542**
Prior period adjustments	-	-	**-**
Gross cost at 1 April 2015 - restated	636	1,906	**2,542**
Gross cost at start of period for new FTs	-	-	**-**
Transfers by absorption	-	-	**-**
Additions	-	203	**203**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Valuation/gross cost at 31 March 2016	**636**	**2,109**	**2,745**
Amortisation at 1 April 2015 - as previously stated	**559**	**742**	**1,301**
Prior period adjustments	-	-	**-**
Amortisation at 1 April 2015 - restated	559	742	**1,301**
Amortisation at start of period for new FTs	**-**	**-**	**-**
Transfers by absorption	**-**	**-**	**-**
Provided during the year	34	278	**312**
Impairments	-	-	**-**
Reversals of impairments	-	-	**-**
Reclassifications	-	-	**-**
Revaluations	-	-	**-**
Transfers to/ from assets held for sale	-	-	**-**
Disposals / derecognition	-	-	**-**
Amortisation at 31 March 2016	**593**	**1,020**	**1,613**
Net book value at 31 March 2016	**43**	**1,089**	**1,132**
Net book value at 1 April 2015	**77**	**1,164**	**1,241**

Note 16.1 Property, plant and equipment - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 - brought forward	**32,766**	**150,428**	**1,853**	**7,523**	**26,440**	**70**	**32,841**	**1,901**	**253,822**
Additions	-	8,086	-	8,040	2,707	-	4,241	23	**23,097**
Impairments	-	(7,201)	(38)	-	-	-	-	-	**(7,239)**
Reversals of impairments	-	2,689	-	-	-	-	-	-	**2,689**
Reclassifications	-	575	-	(575)	-	-	-	-	**-**
Revaluations	-	3,184	99	-	-	-	-	-	**3,283**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(220)	-	(32)	-	**(252)**
Valuation/gross cost at 31 March 2017	**32,766**	**157,761**	**1,914**	**14,988**	**28,927**	**70**	**37,050**	**1,924**	**275,400**
Accumulated depreciation at 1 April 2016 - brought forward	**-**	**-**	**-**	**-**	**19,327**	**36**	**15,941**	**1,503**	**36,807**
Provided during the year	-	5,202	38	-	1,500	6	3,016	48	**9,810**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(5,202)	(38)	-	-	-	-	-	**(5,240)**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals/ derecognition	-	-	-	-	(217)	-	(32)	-	**(249)**
Accumulated depreciation at 31 March 2017	**-**	**-**	**-**	**-**	**20,610**	**42**	**18,925**	**1,551**	**41,128**
Net book value at 31 March 2017	**32,766**	**157,761**	**1,914**	**14,988**	**8,317**	**28**	**18,125**	**373**	**234,272**
Net book value at 1 April 2016	**32,766**	**150,428**	**1,853**	**7,523**	**7,113**	**34**	**16,900**	**398**	**217,015**

Note 16.2 Property, plant and equipment - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 - as previously stated	**39,336**	**153,510**	**2,110**	**3,480**	**27,369**	**70**	**29,366**	**1,898**	**257,139**
*Prior period adjustments	-	-	-	-	(897)	-	(89)	(4)	**(990)**
Valuation/gross cost at 1 April 2015 - restated	**39,336**	**153,510**	**2,110**	**3,480**	**26,472**	**70**	**29,277**	**1,894**	**256,149**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	9,625	198	6,705	1,424	-	1,990	7	**19,949**
Impairments	(1,743)	(20,936)	(526)	-	-	-	-	-	**(23,205)**
Reversals of impairments	-	2,112	-	-	-	-	-	-	**2,112**
Reclassifications	-	403	-	(2,662)	-	-	2,259	-	**-**
Revaluations	650	6,035	71	-	-	-	-	-	**6,756**
Transfers to/ from assets held for sale	(5,477)	(306)	-	-	-	-	-	-	**(5,783)**
Disposals / derecognition	-	(15)	-	-	(1,456)	-	(685)	-	**(2,156)**
Valuation/gross cost at 31 March 2016	**32,766**	**150,428**	**1,853**	**7,523**	**26,440**	**70**	**32,841**	**1,901**	**253,822**
Accumulated depreciation at 1 April 2015 - as previously stated	**-**	**-**	**-**	**-**	**20,017**	**70**	**13,859**	**1,459**	**35,405**
*Prior period adjustments	-	-	-	-	(858)	(39)	(89)	(4)	**(990)**
Accumulated depreciation at 1 April 2015 - restated	**-**	**-**	**-**	**-**	**19,159**	**31**	**13,770**	**1,455**	**34,415**
Provided during the year	-	5,560	57	-	1,601	5	2,856	48	**10,127**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(5,560)	(57)	-	-	-	-	-	**(5,617)**
Transfers to/ from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(1,433)	-	(685)	-	**(2,118)**
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**-**	**19,327**	**36**	**15,941**	**1,503**	**36,807**
Net book value at 31 March 2016	**32,766**	**150,428**	**1,853**	**7,523**	**7,113**	**34**	**16,900**	**398**	**217,015**
Net book value at 1 April 2015	**39,336**	**153,510**	**2,110**	**3,480**	**7,313**	**39**	**15,507**	**439**	**221,734**

* There has been a prior period adjustment made to the 1 April 2015 values for plant and machinery, IT and fixtures and fittings, to correct a presentational error identified; this adjustment had no effect on the Net Book Value of the assets

Note 16.3 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned	32,250	84,201	1,914	14,988	8,167	28	18,067	373	**159,988**
Finance leased	516	-	-	-	-	-	-	-	**516**
On-SoFP PFI contracts and other service concession arrangements	-	72,590	-	-	-	-	-	-	**72,590**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	-	970	-	-	150	-	58	-	**1,178**
NBV total at 31 March 2017	**32,766**	**157,761**	**1,914**	**14,988**	**8,317**	**28**	**18,125**	**373**	**234,272**

Note 16.4 Property, plant and equipment financing - 2015/16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016									
Owned	32,250	78,271	1,853	7,523	6,888	34	16,874	398	**144,091**
Finance leased	516	-	-	-	27	-	-	-	**543**
On-SoFP PFI contracts and other service concession arrangements	-	71,143	-	-	-	-	-	-	**71,143**
PFI residual interests	-	-	-	-	-	-	-	-	**-**
Government granted	-	-	-	-	-	-	-	-	**-**
Donated	-	1,014	-	-	198	-	26	-	**1,238**
NBV total at 31 March 2016	**32,766**	**150,428**	**1,853**	**7,523**	**7,113**	**34**	**16,900**	**398**	**217,015**

Note 17 Donations of property, plant and equipment

During 16/17 the Trust received cash from Calderdale and Huddersfield Charitable Funds of £66k, for items of equipment to be purchased which included: an additional Fibro scanner Probe; 8 x MY Life units for Dementia patients; a printer and scanner for wrist bands for the Neonatal Unit; and a standing aid for adults.

Note 18 Revaluations of property, plant and equipment

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
All assets are measured subsequently at fair value
All property assets are revalued using professional valuations in accordance with IAS 16 every year.
A desktop revaluation was done of all property 31 March 2017.
Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Charted Surveyor (RICS) Appraisal and Valuation Manual.
Specialised operational property is valued using the HM Treasury standard approach of depreciated replacement cost valuation based on modern equivalent assets, and where it would meet the location requirement of the service being provided on an alternative site can be valued.
Non-specialised operational owner-occupied property is valued at existing use value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation
An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Note 19 Investments in associates (and joint ventures)

	2016/17		2015/16
	£000		£000
Carrying value at 1 April	**2,466**		**1,353**
At start of period for new FTs	**-**		**-**
Transfers by absorption	-		-
Acquisitions in year	-		-
Share of profit/(loss)	423		1,113
Impairments	-		-
Reversal of impairment	-		-
Transfers to/from assets held for sale	-		-
Disbursements / dividends received	-		-
Disposals	-		-
Share of Other Comprehensive Income recognised by joint ventures / associates	-		-
Carrying value at 31 March	**2,889**		**2,466**

Note 20 Disclosure of interests in other entities

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This partnership is the Pennine Property Partnership LLP 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.

Disclosure of aggregate amounts for assets and liabilities of jointly controlled operations	**31 March 2017**		**31 March 2016**
	£000		£000
Non current assets	12,588		11,846
Current assets	1,049		751
Total assets	**13,637**		**12,597**
Current liabilities	(1,719)		(1,753)
Non current liabilities	(11,918)		(10,844)
Total liabilities	**(13,637)**		**(12,597)**
Operating income	665		768
Operating expenses	(248)		(328)
Fair Value revaluation Gain	524		913
Surplus /(deficit) for the year	**941**		**1,353**

Note 21 Inventories

	31 March 2017		31 March 2016
	£000		£000
Drugs	2,336		2,495
Work In progress	370		502
Consumables	4,018		3,975
Energy	-		-
Inventories carried at fair value less costs to sell	-		-
Other	-		-
Total inventories	**6,724**		**6,972**

Inventories recognised in expenses for the year, including write-down of inventories were £64,218k (2015/16: £61,791k)

Note 22.1 Trade receivables and other receivables

	31 March 2017		31 March 2016
	£000		£000
Current			
Trade receivables due from NHS bodies	7,223		7,316
Receivables due from NHS charities	-		-
Other receivables due from related parties	-		-
Capital receivables	78		78
Provision for impaired receivables	(1,036)		(1,281)
Deposits and advances	-		-
Prepayments (non-PFI)	2,255		2,176
PFI prepayments:			
Capital contributions	-		-
Lifecycle replacements	-		-
Accrued income	5,952		3,146
Interest receivable	-		-
Corporation tax receivable	-		-
Finance lease receivables	-		-
Operating lease receivables	-		-
PDC dividend receivable	101		235
VAT receivable	966		2,170
Other receivables	3,759		2,673
Total current trade and other receivables	**19,298**		**16,513**
Non-current			
Trade receivables due from NHS bodies	-		-
Receivables due from NHS charities	-		-
Other receivables due from related parties	-		-
Capital receivables	1,675		1,801
Provision for impaired receivables	-		-
Deposits and advances	-		-
Prepayments (non-PFI)	-		-
PFI prepayments:			
Capital contributions	-		-
Lifecycle replacements	-		-
Accrued income	-		-
Interest receivable	-		-
Corporation tax receivable	-		-
Finance lease receivables	-		-
Operating lease receivables	-		-
VAT receivable	-		-
Other receivables	1,455		1,153
Total non-current trade and other receivables	**3,130**		**2,954**

Note 22.2 Provision for impairment of receivables

	2016/17	2015/16 (Restated)
	£000	£000
At 1 April as previously stated	**1,281**	**933**
Increase in provision	98	597
Amounts utilised	(321)	(229)
Unused amounts reversed	(22)	(20)
At 31 March	**1,036**	**1,281**

Note 22.3 Analysis of financial assets

	31 March 2017		31 March 2016 (Restated)	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0 - 30 days	-	-	-	-
30-60 Days	-	-	-	-
60-90 days	-	-	24	-
90- 180 days	183	-	482	-
Over 180 days	853	-	775	-
Total	**1,036**	**-**	**1,281**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	2,560	-	2,353	-
30-60 Days	1,483	-	817	-
60-90 days	773	-	473	-
90- 180 days	388	-	-	-
Over 180 days	536	-	-	-
Total	**5,740**	**-**	**3,643**	**-**

The 15/16 comparatives for notes 22.2 and 22.3 have been restated to meet the requirement of IFRS 7 paragraph 37 (2013 version) to exclude those things that do not meet the definition of a financial asset (such as prepayments and debts arising under statute rather than contract e.g. Injury Cost Recovery). The provisions for impaired receivables has been restated from £1,663k to £1,281k. The ageing of non-impaired financial assets past their due date has been restated from £6,397k to £3,643k.

Note 23 Non-current assets for sale and assets in disposal groups

	2016/17			2015/16
	Intangible assets	**Property, plant & equipment**	**Total**	**Total**
	£000	**£000**	**£000**	**£000**
Net Book Value of non-current assets for sale and assets in disposal groups at 1 April	**-**	**5,783**	**5,783**	**-**
Prior period adjustment	**-**	**-**	**-**	**-**
Net Book Value of non-current assets for sale and assets in disposal groups at 1 April - restated	**-**	**5,783**	**5,783**	**-**
At start of period for new FTs	-	-	-	-
Transfers by absorption	-	-	-	-
Plus assets classified as available for sale in the year	-	-	-	5,783
Less assets sold in year	-	(1,568)	(1,568)	-
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	**-**	**4,215**	**4,215**	**5,783**

The assets classified as held for sale as at 31 March 2017, were two assets of land and buildings namely the St Luke's Hospital site and The Poplars nursery building.
A property disposal review was completed in 2015 which identified 38 Acre Street, The Poplars and Princess Royal Health Centre as surplus to requirements. At 31st March 2017, sales had been completed for Princess Royal and 38 Acre Street. The Poplars sale had been agreed with the current occupants of the building and the sale is expected to complete during 17/18.
At the Board of Directors in January 2016 it was agreed to transfer the St Luke's Hospital site to the Pennine Property Partnership (PPP) in line with the agreement in place on the establishment of the PPP 24th March 2011. The site will transfer at an agreed crystallised value in line with the agreed outline planning consent. The transfer is expected to complete in early spring 2018.

Note 24 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2016/17	2015/16
	£000	£000
At 1 April	**1,938**	**13,697**
Net change in year	3	(11,759)
At 31 March	**1,941**	**1,938**
Broken down into:		
Cash at commercial banks and in hand	65	66
Cash with the Government Banking Service	1,876	1,872
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**1,941**	**1,938**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**1,941**	**1,938**

Note 24.1 Third party assets held by the NHS foundation trust

Calderdale & Huddersfield NHS Foundation Trust held cash and cash equivalents which relate to monies held by the the foundation trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2017	31 March 2016
	£000	£000
Bank balances	2	-
Monies on deposit	7	7
Total third party assets	**9**	**7**

Note 25.1 Trade and other payables

	31 March 2017	31 March 2016
	£000	£000
Current		
Receipts in advance	-	-
NHS trade payables	596	2,439
Amounts due to other related parties	-	-
Other trade payables	13,307	17,398
Capital payables	9,611	3,714
Social security costs	-	-
VAT payable	-	-
Other taxes payable	4,442	4,006
Other payables	2,698	2,524
Accruals	10,882	9,495
PDC dividend payable	-	-
Total current trade and other payables	**41,536**	**39,576**
Non-current		
Receipts in advance	-	-
NHS trade payables	-	-
Amounts due to other related parties	-	-
Other trade payables	-	-
Capital payables	-	-
VAT payable	-	-
Other taxes payable	-	-
Other payables	164	245
Accruals	-	-
Total non-current trade and other payables	**164**	**245**

Note 26 Other liabilities

	31 March 2017		31 March 2016
	£000		£000
Current			
Deferred grants income			-
Deferred goods and services income	1,455		1,138
Deferred rent of land income	-		-
Other deferred income	97		97
Deferred PFI credits	-		-
Lease incentives	-		-
Total other current liabilities	**1,552**		**1,235**
Non-current			
Deferred grants income	-		-
Deferred goods and services income	-		-
Deferred rent of land income	-		-
Other deferred income	1,339		1,353
Deferred PFI credits	-		-
Lease incentives	-		-
Net pension scheme liability	-		-
Total other non-current liabilities	**1,339**		**1,353**

Note 27 Borrowings

	31 March 2017		31 March 2016
	£000		£000
Current			
Bank overdrafts	-		-
Drawdown in committed facility	-		-
Loans from the Department of Health	2,571		1,713
Other loans	-		-
Obligations under finance leases	-		-
PFI lifecycle replacement received in advance	-		-
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	1,482		1,405
Total current borrowings	**4,053**		**3,118**
Non-current			
Loans from the Department of Health	59,206		30,236
Other loans	-		-
Obligations under finance leases	-		-
Obligations under PFI, LIFT or other service concession contracts	76,008		77,490
Total non-current borrowings	**135,214**		**107,726**

Note 28 Provisions for liabilities and charges analysis					
	Pensions - early departure costs	**Other legal claims**	**Re-structurings**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2016	**1,375**	**159**	**513**	**2,630**	**4,677**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-
Change in the discount rate	61	-	-	103	164
Arising during the year	4	128	-	495	627
Utilised during the year	(255)	(91)	-	(135)	(481)
Reclassified to liabilities held in disposal groups	-	-	-	-	-
Reversed unused	(39)	(52)	(158)	(590)	(839)
Unwinding of discount	34	-	-	2	36
At 31 March 2017	**1,180**	**144**	**355**	**2,505**	**4,184**
Expected timing of cash flows:					
- not later than one year;	254	144	355	1,125	1,878
- later than one year and not later than five years;	628	-	-	554	1,182
- later than five years.	298	0	0	826	1,124
Total	**1,180**	**144**	**355**	**2,505**	**4,184**
* Of the £2.5m other provisions £1.3m relates to Injury benefits					

Note 28.1 Clinical negligence liabilities
At 31 March 2017, £188,216k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Calderdale & Huddersfield NHS Foundation Trust (31 March 2016: £140,894k).

Note 29 Contingent assets and liabilities
There were no contingent liabilities or assets to disclose at 31 March 2017 or 31 March 2016.

Note 30 Contractual capital commitments			
	31 March 2017		**31 March 2016**
	£000		**£000**
Property, plant and equipment	6,052		5,209
Intangible assets	-		-
Total	**6,052**		**5,209**

Note 31 Contractual capital commitments	31 March 2017		31 March 2016
The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements) at 31 March 2017 as follows, analysed by the period during which the payment is made:	2,373		2,171
not later than 1 year	10,186		8,681
after 1 year and not later than 5 years	7,324		8,320
paid thereafter	**19,883**		**19,172**
Total			

This commitment relates to a contract with Cerner Ltd to deliver an Electronic Patient Record system and includes costs relating to Bradford Teaching Hospital NHS Foundation Trust. The contractual commitment remains with Calderdale & Huddersfield NHS Foundation Trust as the contract signatory.

Calderdale & Huddersfield NHS Foundation Trust has a back to back legal agreement with Bradford Teaching Hospital NHS Foundation Trust to idemnify Calderdale and Huddersfield NHS Foundation Trust against any associated risk.

Note 32 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has a PFI scheme for Calderdale Royal Hospital. The PFI contractor is Calderdale Hospitals SPC Ltd (formerly Catalyst Healthcare Ltd). The Trust are responsible for the provision of all clinical services, Calderdale Hospitals SPC Ltd provide fully serviced hospital accommodation.

Note 32.1 Imputed finance lease obligations

The trust has the following obligations in respect of the finance lease element of on-Statement of Financial Position PFI and LIFT schemes:

	31 March 2017		31 March 2016
	£000		£000
Gross PFI, LIFT or other service concession liabilities	**264,063**		**275,338**
Of which liabilities are due			
- not later than one year;	12,436		12,211
- later than one year and not later than five years;	53,736		50,904
- later than five years.	197,891		212,223
Finance charges allocated to future periods	(186,573)		(196,443)
Net PFI, LIFT or other service concession arrangement obligation	**77,490**		**78,895**
- not later than one year;	1,482		1,405
- later than one year and not later than five years;	8,162		6,622
- later than five years.	67,846		70,868

Note 32.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2017		31 March 2016
	£000		£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	463,582		487,436
Of which liabilities are due:			
- not later than one year;	26,167		25,559
- later than one year and not later than five years;	110,005		107,450
- later than five years.	327,410		354,427

Note 32.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's payments in 2016/17:

	31 March 2017		31 March 2016
	£000		£000
Unitary payment payable to service concession operator	25,712		25,331
Consisting of:			
- Interest charge	6,715		6,843
- Repayment of finance lease liability	1,405		1,497
- Service element and other charges to operating expenditure	11,381		11,220
- Capital lifecycle maintenance	1,430		1,129
- Revenue lifecyle maintenance	646		589
- Contingent rent	4,135		4,053
- Addition to lifecycle prepayment	-		-
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	-		-
Total amount paid to service concession operator	**25,712**		**25,331**

Note 33 Financial instruments

Note 33.1 Financial risk management

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 and the Trust's approach to borrowing. The policy, and its implementation are reviewed by the Audit & Risk Committee and the Board of Directors. The Trust's treasury management activity is subject to review by the Trust's internal auditors.

Interest rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. The Trust therefore currently 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 regular in-year adjustments to reflect actual levels of income due.

To finance the Trust's deficit position the Trust required loan funding in 2016/17 as was the case in 2015/16. The drawdown of revenue borrowing totalled £26.9m in 2016/17 and was secured from Department of Health in the form of an Interim Revenue Support Facility at an interest rate of 1.5%.

In 2016/17 the Trust has financed part of its capital expenditure from internally generated funds with the balance of £5m funded from a Capital loan from Department of Health.

The Trust's 2017/18 plan which has been approved by NHS Improvement recognises that the Trust will require cash support from the Department of Health of £28.8m which will be drawn down on a monthly basis, the Trust is therefore, not exposed to significant liquidity risk.

Currency risk

The Trust is principally a domestic organisation with negligible transactions, assets and liabilities in foreign currencies. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Note 33.2 Financial assets

	Loans and		Held to maturity	Available-for-sale	Total
	£000		£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	9,620	-	-	-	9,620
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,941	-	-	-	1,941
Total at 31 March 2017	**11,561**	**-**	**-**	**-**	**11,561**

	Loans and		Held to maturity	Available-for-sale	Total
	£000		£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	9,278	-	-	-	9,278
Other investments	-	-	-	-	-
Other financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	1,938	-	-	-	1,938
Total at 31 March 2016	**11,216**	**-**	**-**	**-**	**11,216**

Note 33.3 Financial liabilities

			Other financial liabilities	Liabilities at fair value through the I&E	Total
			£000	£000	£000
Liabilities as per SoFP as at 31 March 2017					
Embedded derivatives			-	-	-
Borrowings excluding finance lease and PFI liabilities			61,777	-	61,777
Obligations under finance leases			-	-	-
Obligations under PFI, LIFT and other service concession contracts			77,490	-	77,490
Trade and other payables excluding non financial liabilities			37,094	-	37,094
Other financial liabilities			-	-	-
Provisions under contract			-	-	-
Total at 31 March 2017			**176,361**	**-**	**176,361**

			Other financial liabilities	Liabilities at fair value through the I&E	Total
			£000	£000	£000
Liabilities as per SoFP as at 31 March 2016					
Embedded derivatives			-	-	-
Borrowings excluding finance lease and PFI liabilities			31,949	-	31,949
Obligations under finance leases			-	-	-
Obligations under PFI, LIFT and other service concession contracts			78,895	-	78,895
Trade and other payables excluding non financial liabilities			35,851	-	35,851
Other financial liabilities			-	-	-
Provisions under contract			-	-	-
Total at 31 March 2016			**146,695**	**-**	**146,695**

Note 33.4 Maturity of financial liabilities

				31 March 2017	31 March 2016
				£000	£000
In one year or less				41,148	38,999
In more than one year but not more than two years				16,629	3,696
In more than two years but not more than five years				38,163	9,331
In more than five years				80,421	94,669
Total				**176,361**	**146,695**

Note 33.5 Fair values of financial assets at 31 March 2017

				Book value	Fair value
				£000	£000
Non-current trade and other receivables excluding non financial assets				-	-
Other investments				2,889	2,889
Other				-	-
Total				**2,889**	**2,889**

Note 33.6 Fair values of financial liabilities at 31 March 2017					
				Book value	**Fair value**
				£000	**£000**
Non-current trade and other payables excluding non financial liabilities				-	-
Provisions under contract				-	-
Loans				59,206	59,206
Other				-	-
Total				**59,206**	**59,206**

Note 34 Losses and special payments					
	2016/17			**2015/16**	
	Total number of cases	**Total value of cases**		**Total number of cases**	**Total value of cases**
	Number	**£000**		**Number**	**£000**
Losses					
Cash losses	-	-		2	(0)
Fruitless payments	-	-		-	-
Bad debts and claims abandoned	12	16		3	106
Stores losses and damage to property	1	54		1	67
Total losses	**13**	**70**		**6**	**173**
Special payments					
Extra-contractual payments	-	-		-	-
Extra-statutory and extra-regulatory payments	-	-		-	-
Compensation payments	25	92		15	49
Special severence payments	-	-		-	-
Ex-gratia payments	24	10		40	26
Total special payments	**49**	**102**		**55**	**75**
Total losses and special payments	**62**	**172**		**61**	**248**
Compensation payments received					

Note 35 Prior period adjustments

Calderdale & Huddersfield NHS foundation Trust is the corporate trustee to Calderdale & Huddersfield NHS Foundation Trust charitable fund. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust is exposed to, or has rights to variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. The Foundation Trust has assessed that the values involved are not of material nature and the Trust Board has approved and agreed not to consolidated the Charitable Funds. The 15/16 comparatives have been restated due to this change in accounting policy and the Group Account values have been removed.

Note 36 Events after the reporting date

There are no disclosable events after the reporting period.

Note 37.1 Related parties

The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24.
The Department of Health Group Accounting Manual 2016/17, 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	**2016/17**	**2015/16**
	£000	**£000**
Income - NHS Calderdale CCG	143,239	136,738
Income - NHS Greater Huddersfield CCG	126,580	121,186
Income - NHS North Kirklees CCG	6,775	5,559
Income - NHS Bradford Districts CCG	7,185	7,124
Income - NHS Wakefield CCG	3,140	1,002
Income - Leeds Teaching Hospitals NHS Trust	1,266	1,140
Income - South West Yorkshire Partnership NHS Foundation Trust	3,760	3,928
Income - Health Education England	8,943	438
Income- Yorkshire and the Humber Commissioning Hub	23,294	13,310
Income- Yorkshire and the Humber Local Office	7,364	16,296
Income - Other WGA	34,048	32,696
Income - Total with WGA organisations	**365,594**	**339,417**
Charitable Funds	399	405
Income - Total	**365,993**	**339,822**
Expenditure - Bradford Teaching Hospitals NHS Foundation Trust	1,081	1,079
Expenditure - Leeds Teaching Hospitals NHS Trust	2,139	1,508
Expenditure - NHS Pension Scheme	22,342	21,336
Expenditure - NHS Litigation Authority	15,758	11,569
Expenditure - HMRC	16,594	12,497
Expenditure - Other WGA	7,056	6,200
Expenditure - Total with WGA organisations	**64,970**	**54,189**
Joint Ventures	1,215	1,673
Expenditure - Total	**66,185**	**55,862**

Note 37.2 Related Party Balances

Related party balances - WGA organisations	**31 March 2017**	**31 March 2016**
	£000	**£000**
Receivables - NHS Calderdale CCG	2,392	2,374
Receivables - NHS Greater Huddersfield CCG	1,173	1,512
Receivables - NHS England	5,198	1,946
Receivables - HM Revenue & Customs - VAT	966	2,170
Receivables - Other WGA	4,406	4,511
Charitable Funds	72	25
Receivables - Total with WGA organisations	**14,207**	**12,538**
Payables - NHS Pension Scheme	3,148	2,953
Payables - HMRC	4,442	4,006
Payables - Other WGA	1,724	3,061
Payables - Total with WGA organisations	**9,314**	**10,020**

During the year, the following Board Members or members of the key management staff have declared the following interest or parties related to them.

A Haigh ~ Chair - is a Non Executive Director of Furness Building Society.

D Anderson ~ Non Executive Director - Is Director of Synergy P, Prime Health Huddersfield Ltd and Grange Group Practice.

J Wilson ~ Non Executive Director - is a Director of Groundwork Wakefield Limited, Trustee/Chair Job Match (UK) Ltd, 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, is a Trustee of Health Quality Improvement Partnership.

P Oldfield ~ Non Executive Director - Director and Owner of Tanzuk Consulting holds a position of authority with Sue Ryder Livability and at home in the community, Director for Young Epilepsy.

Prof P Roberts ~ Non Executive Director - is a Director of Pennine Property Partnership LLP, Partner of Catchweasel, Chair of First Ark group, Vice Chair of Northern Ireland Housing Executive, Ty Hen Holidays LLP Partner and is Chair of Planning Exchange foundation, Town and Country Planning Association Vice President, Non Executive Director Genesis Housing.

R Hopkin ~ Non Executive Director - Directorship of Capri Finance Ltd - own consultancy company. All part of 'Derwent' Group - Derwent Housing Association Ltd Derwent FM Ltd Centro Place Investments Ltd. Finance Director (part time) of Age UK Calderdale and Kirklees. Unpaid Treasurer of Community Foundation for Calderdale.

K Heaton ~ Non Executive Director - Independent Board Director of One Manchester Ltd.

K Griffiths ~ Director of Finance - Was Director of Pennine Property Partnership LLP (To 28.10.16).

G Boothby ~ Director of Finance - Is a Director of Pennine Property Partnership LLP

L Hill ~ Director Planning, Estates and Facilities - is a Director of Pennine Property Partnership LLP, and a Trustee of Dean Clough Foundation.

D Birkenhead ~ Medical Director - is a Trustee of Children's Forget Me Not Trust. Wife- GP Partner at Colne Valley Group Practice.

O Williams ~ Chief Executive - is a Trustee of the NHS Confederation, Director of York Health Economics Consortium.

H Barker ~ Chief Operating Officer - Company Secretary and Shareholder of Expert Lighting Direct Ltd makes sales to NHS.

In 16/17 there were transactions between Calderdale & Huddersfield NHS Foundation Trust and related parties, additional to those declared under the scope of Whole of Government accounts.

The Foundation Trust had expenditure with Pennine Property Partnership LLP in 16/17 £927,753 (15/16 £1,672,747), there was no creditor balance at year end.

The expenditure between the Trust and NHS Confederation in 16/17 £0.00 (15/16 £7,854).

The expenditure between the Trust and York Health Economics Consortium in 16/17 was £0.00 (15/16 £240)

The Foundation Trust had expenditure with Forget Me Not Trust in 16/17 £250 (15/16 £1,101), the was no creditor balances at year end.

The Foundation Trust had expenditure with Grange Group Practice Fartown in 16/17 £21,060 (15/16 £2,557), there was no creditor balance at year end.

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