One Culture of care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Annual Report and Accounts 2021/22

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compassionate care

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts

2021/22

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1. Chair's Statement

I find myself in a reflective mood as I pen this, my last statement as Chair of Calderdale and Huddersfield NHS Foundation Trust (CHFT).

I've been searching for the right words to describe my admiration and deep respect for each and every member of the CHFT family, for everything they have done to deliver compassionate care for our communities over the last tumultuous year.

One word sums up my feelings more than any other - proud. I'm filled with pride as colleagues unceasingly went the extra mile to support our patients and each other despite the pandemic and the relentless and ever growing pressure facing our services.

You see, when the going gets tough at CHFT we pull together with one culture of care. We have demonstrated time and time again that we can weather the toughest storms with unshakable dedication and professionalism.

The entire NHS was awarded the George Cross, Britain's highest civilian award for gallantry and if I could, I would pin a medal on every one of my colleagues.

There are so many reasons to be proud of my time at CHFT, our pioneering work on tackling health inequalities, our commitment to partnership working as a leading voice within our regional health and care system and with groundworks already underway, I can't forget our ambitious reconfiguration plans, which will not only improve our estate, but also allow us to embrace innovative new practices and fully realise the transformative power of technology to deliver health and care services.

It has been an immense privilege to play my small part in supporting the Trust these last four years. It has been the most challenging, and yet the most rewarding experience of my career.

As we look to the future, to a post pandemic world, the Trust faces many more challenges, but I know with certainty that the CHFT family will continue to scale any mountain they face with the same grit, determination, and compassion and, as ever, I will be cheering you on, with pride.

Philip Lewer – Chair

WINDSOR CASTLE

It is with great pleasure, on behalf of a grateful nation, that I award the George Cross to the National Health Service of the United Kingdom.

This award recognises all N.H.S. staff, past and present, across all disciplines and all four nations. Over more than seven decades, and especially in recent times, you have supported the people of our country with courage, compassion and dedication, demonstrating the highest standards of public service.

You have our enduring thanks and heartfelt appreciation.

Elizabeth R

Letter from the Queen awarding the George Cross to the NHS

2. PERFORMANCE REPORT

Overview of performance

Statement from the Chief Executive

It has been a real privilege to return to CHFT as the new Chief Executive of the Trust and a pleasure to write this foreword as we reflect on our achievements and the many challenges this last year has thrown our way. The relentless dedication of our colleagues, who without hesitation or complaint have responded to some of the most challenging times in their working careers, speaks to the cornerstone of this organisation; its people, who I am proud to lead.

I wanted to start by paying tribute to Philip Lewer who has served as the Chair of the Trust for the last four years. His support for me, the Board of Directors, our colleagues, our governors and most importantly our patients and the communities we serve has been tremendous and his passion for delivering compassionate care has been an inspiration to us all.

Over the past year there have been several changes to our leadership team, with my predecessor Owen Williams embarking on new challenges as Chief Executive of the Northern Care Alliance. We have also said goodbye to Helen Barker who retired as our Chief Operating Officer in 2021 and Mandy Griffin who retired as our Managing Director of our Health Informatics Service. In June of this year, we will also say farewell to Ellen Armistead who is retiring as our Chief Nurse. I'm sure you will join me in thanking them all for their dedicated service.

Of course, with change comes new opportunities and we will soon welcome Helen Hirst as our new Chair. We have warmly welcomed Jo Fawcus as our new Chief Operating Officer. We will shortly be joined by Victoria Pickles as our Director of Corporate Affairs, and Lindsay Rudge as Interim Chief Nurse.

I must also take this opportunity to pay my own tribute to our colleagues who have collectively cared for our patients and their families through continued surges of the Covid-19 pandemic. These have continued to be in extremely uncertain, complex, and pressurised conditions in the midst of increases in acute demand, all whilst sustaining our elective care. I share Philip's pride in every one of our colleagues for their fortitude and commitment. They are a credit to the Trust and our communities as inspirational public servants.

Our Trust is very much a team player and so we continued to work in partnership at a local and regional level to ensure the very best services for the communities we serve. So, I must also pay tribute to our system partners. A significant benefit of the pandemic has been the increase in collaborative working across both Calderdale and Kirklees. We are working more closely and more effectively than ever and it's a testament to this hard work that we have been able to sustain so much of our elective work thanks to the system response we have planned together around discharge to care.

We look forward to building on this collaboration with our local place based partners in Calderdale and Kirklees when the new place based committees of the West Yorkshire Integrated Care Board are established. Our partnerships extend beyond traditional health

settings, and I am optimistic working with health, primary care, local authority, voluntary sector, social care, hospice and education colleagues across the breadth of our region will contribute to making this new delivery architecture successful.

The Trust is also a member of the West Yorkshire Association of Acute Trusts (WYAAT), which brings together six local NHS trusts across West Yorkshire and Harrogate to provide region-wide efficient and sustainable healthcare that uses innovation and best practice to benefit patients. This deepening of collaboration helps to ensure the best possible experience and outcomes for our patients and will play a vital role in plans for West Yorkshire's elective recovery.

Despite everything we have faced the Trust continues to make good progress to reduce the numbers of people waiting for treatment and has made tremendous efforts to ensure delivery of key waiting time standards for Cancer.

Our reconfiguration plans also continue to progress at pace. With planning permissions now in place, we have already broken ground in Huddersfield with work due to commence in Calderdale very soon, dependant on further Treasury approval. Our ambitious plans will not only improve our estate but as digital leaders, also allow us to introduce innovative new practices that fully realise the transformative power of technology to deliver exceptional health and care services and will support the longer-term resilience of acute and emergency service provision.

So, as I look to the future, yes, I recognise the substantial challenges we will continue to face. However, I'm also filled with optimism and excitement about the future opportunities that lie ahead of us. I look forward with confidence and a renewed sense of purpose to the chapter we're yet to write.

Professor Brendan Brown
Chief Executive

Performance Report: Performance Overview

The purpose of this overview section of our Annual Report is to provide a short summary of the Trust, our purpose, history, the key risks to the achievement of our objectives and our performance during the year.

Introduction to Calderdale and Huddersfield NHS Foundation Trust

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, Acre Mills Outpatients, Acre Street, Lindley, Huddersfield, West Yorkshire HD3 3EB

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

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

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

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

Calderdale and Huddersfield NHS Foundation Trust is an integrated trust. It provides acute and community health services. The Trust serves two populations; Greater Huddersfield which has a population of 245,000 people and Calderdale with a population of 220,000 people. The Trust operates acute services from two main hospitals; Calderdale Royal Hospital and Huddersfield Royal Infirmary and staff provide care from our community sites, health centres and in our patients' homes.

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

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

The Trust has approximately 650 beds open. We employ approximately 6,581 colleagues (including Calderdale and Huddersfield Solutions Limited) and have 142 volunteers. In 2021/22 we cared for more than 108,000 men, women and children as inpatients (who stayed at least one night) or day cases. There were also over 439,000 outpatient attendances; over 172,000 accident and emergency attendances and just over 4,700 babies delivered. There were some 322,000 adult services contacts by our community teams as well as almost 212,000 contacts with our therapy services.

Our history

The Trust was formed in 2001 combining hospitals in Halifax and Huddersfield to deliver healthcare for the populations of Calderdale and Huddersfield. Calderdale and Huddersfield NHS Foundation Trust is a statutory body, which became a public benefit corporation on 1 August 2006 following its approval as a NHS Foundation Trust by the Independent Regulator of NHS Foundation Trusts (Independent Regulator) authorised under the Health and Social Care (Community Health and Standards) Act 2006 (the 2006 Act). 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. Our governors and members ensure that we are accountable and listen to the needs and views of our patients.

Since 2001 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. In 2006 maternity and surgical services were reconfigured to provide obstetric maternity care and most children's inpatient services on the Calderdale site and trauma surgery on the Huddersfield site. Stroke care was also centralised on the Calderdale site. In 2015 we opened our state of the art outpatients centre in Acre Mills in Lindley, Huddersfield and won the tender to provide sexual health services in Calderdale in a joint bid with the Calderdale GP Federation. During 2017 cardiology and respiratory services were co-located at Calderdale Royal Hospital and all elderly medical services were moved to Huddersfield Royal Infirmary alongside a new frailty service which now operates on both sites. In 2018/19 our acute stroke service was delivered from the Calderdale site. During the winter of 2019/20 we piloted a discharge lounge to support improved patient flow and introduced a same day discharge unit to support frail patients. For the last two years the Trust has adapted its service delivery in response to the Covid-19 pandemic and in 2021/22 has also focused on tackling backlogs built up during the Covid19 pandemic.

2021/22 - Highlights of our year

As the Covid-19 pandemic continued significant clinical and service challenges remained into 2021/ 22. Despite this we were pleased to still receive support from our local communities. Working in a different way also drove innovation and transformation of our services. A selection of highlights from the last year is given below.

In **April** innovation by nursing staff received national recognition for the Ascitic Drain Service (ascitic drains are used to drain excess fluid away from the stomach), winning the British Journal of Nursing Innovation Award. The team on ward 17 developed an elective drain service that has reduced patients' length of stay from an average of 4.5 days to 6 hours. This has given patients freedom to plan their lives, give them control over their illness and knowledge that there is 24 hour support. The clinic gives the patients the flexibility to change their appointments and attend according to their needs and ability to access support groups, medical advice, regular wellbeing check-ups and medication reviews.

In **May** two of our patients and their families took part in making a film to promote the Thinking Ahead Programme run by the Macmillan Information Service. The film is promoting the programme which is being run collaboratively with Harrogate and Leeds Hospital Trusts and is encouraging families to have earlier conversations about end of life planning.

May also saw the Covid vaccination teams ending after having given nearly 50,000 jabs for our communities through joint work with our partners on the vaccination programme.

The Early Pregnancy Assessment Unit (EPAU) is a specialist team providing urgent care service for complications in early pregnancy. Caesarean scar pregnancy is a potentially life-threatening complication of early pregnancy, and it is known to present with diagnostic and management challenges. In **June** one of our doctors presented the experience at Calderdale Royal Hospital and proposed a diagnostic and management algorithm for this complex condition to the Joint Annual Scientific Meeting held by Royal College of Obstetrics and Gynaecology (RCOG) and British Society of Gynaecological Imaging (BSGI). This study won the first prize in oral presentation category among the top five nationally shortlisted projects.

In **July** we saw another digital first when we were the first Trust to launch a new shared maternity electronic patient record system across West Yorkshire and Harrogate. The record, centred around the mother and child, allows all Trusts involved within the local maternity system to share documents relating to care during a woman's pregnancy journey. It means that if a woman booked at CHFT goes to a neighbouring Trust for care during her pregnancy, that Trust can check the portal for any real-time maternity information relating to the woman across all care providers and between different IT systems safely and securely. Likewise, if we are caring for someone booked elsewhere, our colleagues will be able to do the same. Our Health Informatics Service colleagues played a key role in supporting the technical work to make this happen.

In **July**, the entire National Health Service was granted Britain's highest civilian award for gallantry, the George Cross. The NHS is only the third group of people ever to receive the award collectively as it is usually given to individuals. We were pleased that this award recognised the hard work of Trust staff and all NHS staff, past and present,

across all disciplines for “supporting the people of our country with courage, compassion and dedication, demonstrating the highest standards of public service.”

In **August** we celebrated ten years since the first percutaneous coronary intervention (PCI) was carried out at Calderdale Royal Hospital and around 5,000 patients have benefitted from the non-surgical procedure, which is to put a stent into the coronary artery. The procedure provides a timely service with greater accessibility for patients in Kirklees and Calderdale who have symptoms as a result of coronary artery disease and those patients who experience a heart attack. During the pandemic we also supported Leeds General Infirmary with primary PCIs - emergency treatment for the sickest heart attack patients, which is often life-saving.

10 years of stents at Calderdale Royal Hospital

PCIs (percutaneous coronary intervention) - the Calderdale Royal Hospital (CRH) Angiography Team celebrated performing stents at CRH, for 10 years.

September saw our CHUFT awards celebrating our colleagues and their work across the Trust with awards for:

- delivering compassionate care
- demonstrating One Culture of Care (looking after our colleagues)
- Making a Difference (taking services to vulnerable people)
- Going the extra mile (Enhanced Care team)
- Team of the Year (Bereavement Support Service)
- Rising Superstar

In **October** our estates, facilities and procurement provider, CHS Ltd has again been named in the Kirklees Top 100 Companies, moving up a huge 58 places to 25th spot, a real testimony to the continued commitment of all 450 colleagues within CHS working at HRI and CRH. The improved ranking after such a challenging year proves the calibre and reputation of our workforce and shone a light on the work they do to support compassionate care. CHS Ltd then went on to win the community award section of the Huddersfield Examiner Business awards in March 2022 which showcased companies with a conscience and a commitment to social responsibility who really make an impact on their communities.

Calderdale Huddersfield Solutions Ltd moves up to number 25 in the Kirklees Top 100 companies list

November saw work that had taken place by CHS to create a specific Covid isolation ward, ward 18 at Huddersfield Royal Infirmary, which opened in December 2020, winning a national award. The ward, which was completed in ultra -quick time, was recognised at the Building Better Healthcare national awards, winning three awards including the clinicians' Choice award.

Also, in **November** the Macmillan Information and Support Team, along with our Lead Cancer Nurse won a national Macmillan Professionals Excellence Award in the "Whatever It Takes" category. It recognised their contribution during the pandemic, offering crucial virtual support to cancer patients, from diagnosis through to end of life and for co-designing virtual education programmes with and for patients.

Macmillan Professionals Excellence Award win

Macmillan Information and Support Team, along with Christopher Button, Cancer Support Nurse, win national award

In **December** we launched an exciting new pilot service known as 'Pharmacy Led Safari Discharge' which aims to provide a safer and quicker way to get timely discharge prescriptions written and medicines supplied to patients as they are discharged from hospital. The new Safari team is made up of dedicated pharmacy team members and a junior doctor – they will support the discharge process from start to finish including writing the narrative of the take home medications, prescribing the medication, checking what medication the patient already has, dispensing the medication (where possible at the patient's bedside) and counselling the patient so they can understand their medication.

Members of the SAFARI team help patients go home quicker with timely discharge prescriptions. Pictured left to right are: Mandy Madigan, Pharmacy Technician, Sam Turner, Quality Improvement Manager, Katherine Cullen, Deputy Clinical Director of Pharmacy.

In **January 2022** Surgical Advanced Clinical Practitioner, Liam Stout was named the winner of the first ever Innovation Voucher Competition launched in partnership with medical device companies. Liam was awarded a voucher worth up to £5,000 to further develop his concept for abscess management, which aims to reduce the need for surgery, promoting faster recovery times and pain improvements for patients.

Also, in January our finance team received Future Focussed Finance Accreditation Level 2 and joined only 34 other Finance teams in the country to achieve this level of accreditation by the Finance Leadership Council which recognises organisations that have the very best finance skills development culture and practices in place.

In **February** our district nursing team were one of the first Trusts in the country to offer Covid treatments to clinically vulnerable patients in their own homes, preventing patients deteriorating, keeping them safe and out of hospital. This new service was developed through community staff working with pharmacy colleagues and physicians.

In **February** we celebrated our first ever four Professional Nurse Advocates (PNAs) in the Community Healthcare Division. The role of the PNA is to address the emotional needs of colleagues helping them feel supported and valued, with positive outcomes such as improved job satisfaction and working relationships. The PNAs support colleague health and wellbeing by introducing restorative supervision, which is an evidence-based support tool. It's designed for professionals working with complex caseloads and allows them to process natural feelings and focus on their own learning and development needs. Restorative supervision allows practitioners to slow down, mentally and physically with the opportunity to discuss, reflect and receive open and honest feedback.

Community Healthcare Division's first ever Professional Nurse Advocates (PNAs)

District Nurse, Ansah Jamil; Clinical Manager, John Scaife; Community Matron, Rachel Jackson and Clinical Manager, Jayne Duffy

In **March** building work on our new Emergency Department at Huddersfield Royal Infirmary began. We look forward to completing the build by summer 2023 to provide state-of-the-art facilities for our patients. Also, in March planning permission for the future development of a new clinical building at Calderdale Royal Hospital (that will provide additional wards, theatres and a new accident and emergency department as well as a multi-storey car park) was granted by Calderdale Council.

Building work on our new Emergency Department (ED) at HRI gets underway:

Pictured, left to right: ED Matron, Stacey Cartwright; Sister, Fiona Armitage; Joint clinical lead for Transformation and Reconfiguration Mark Davies; General Manager for Medicine, Jason Bushby; Head of Estates, Tom Donaghey and Integrated Health Products' Senior Construction Manager.

Our vision and values

Our vision for Calderdale and Huddersfield Foundation Trust 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 colleagues to follow and which are embedded into the organisation so that every member of staff understands their responsibilities. These are:

Our goals

In November 2021, the Board of Directors agreed an 18 month plan to March 2023 which described the four goals of the Trust. This set out the key areas of delivery to support the achievement of each of the goals described in the table below.

Further detail on how the Trust has progressed these goals is provided in the Performance Analysis section.

Strategic Objectives (November 2021 – March 2023)

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	**Sustainability**
	Implement a programme of transformation based on learning from the COVID-19 pandemic to deliver 'Business Better than Usual' demonstrating benefits delivered. (AB)	Stabilise the delivery of services in response to the COVID-19 pandemic to minimise the loss of life and protect colleagues safety. (EA)	Develop and implement flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for clinical roles, thus retaining a turnover below 10%. (SD)	Deliver the regulator approved financial plan. (GB)
	Approval of business cases for HRI and CRH to enable construction of new A&E to commence at HRI and the development of a Full Business Case for CRH. (AB)	Maintain the Trust CQC overall rating of 'good' and increase the number of services achieving an out-standing' rating. (EA)	Develop an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions. (SD)	Demonstrate improved performance against Use of Resources key metrics. (GB)
	Progress implementation of the Trust's Clinical Strategy working with partner organisations across West Yorkshire. (DB)	Involve patients and the public to influence decisions about their personal care and improve patient experience by: • responding to the needs of people from protected characteristics groups • implementing "Time to Care". • achieving patient safety metrics (EA)	Revise our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams through Recovery and beyond (SD)	Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust's carbon footprint. (SS)
	Implement the Trust Board approved 5 year digital strategy with an agreed programme of work and milestones. (JR)	Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery. (JF)	Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of the workforce. (SD)	Collaborate with partners across West Yorkshire and in place to deliver resilient system plans. (AB)
	Use population health data to inform and implement actions to address health inequalities in the communities we serve. (EA)	Deliver the actions in the Trust's Health and Safety Plan. (SD)	Develop health and wellbeing support plans for all Departments to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey. (SD)	

Key issues, risks and opportunities

The Trust has mechanisms in place to manage risk, supported by the Trust governance structure, risk management strategy and policy and risk appetite. Further details can be found in the Annual Governance Statement which describes our risk management processes in detail.

As stated above, in November 2021 the Board of Directors agreed an 18 month plan setting out its key areas of delivery for years two and three of a 10 year strategy agreed at the Board in March 2020. 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:

- Transforming and improving patient care
- Keeping the base safe
- A workforce for the future
- Sustainability

Key issues and risks 2021/22

The principal risks the Trust faced in 2021/22 in achieving the four goals detailed above are described in the Board Assurance Framework, a tool to assure the Board about the achievement of strategic objectives. The risks are detailed in the table below.

Board Assurance Framework risks to our goals - year ending March 2022

Transforming and improving patient care risks
The Trust does not secure approval of the Hospital Services Reconfiguration Strategic Outline Case, Outline Business Case and Full Business Case resulting in being unable to progress changes to improve quality of care, workforce resilience and mitigate estates risks.
The Trust will be unable to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.
The Trust does not listen, involve and engage patients and the public to influence decisions about their personal care, delivery and improvement of services, and people from black, minority ethnic groups and all other protected characteristic groups receive suboptimal care due to lack of capacity and capability to respond in a meaningful way to patient and service user feedback resulting in services not being designed using patient recommendations.
Risk of not delivering the ambitions in the Trust clinical strategy due to lack of collaboration due to lack of time, commitment, relationships and absence of shared vision, resulting in missed opportunities in terms of quality, efficiency, capacity, patient experience and workforce.
Risk of not securing appropriate investment to fund the Digital Strategy ambitions, ensuring infrastructure and technology is up to date and future proof due to funding not being available locally and nationally impacting on workforce efficiency and patient experience.

Risk that the Trust does not embed learning from experience during the Covid-19 Pandemic to inform future delivery models and sustain the examples of positive and accelerated service transformation, resulting in the Trust not being able to stabilise the future delivery of services and missing opportunities for improvement in the quality, experience and efficiency of service delivery.
Risk of slow progress addressing health inequalities in the 20% of the most deprived patients in our communities, due to incomplete data, mismatch between service and deprivation, lack of quality priorities to advance health equity and health prevention, ineffective partnership working resulting in the Trust not reducing health inequalities for our most vulnerable patients with protected characteristics.

Keeping the base safe risks
Patients do not receive high quality, safe care due to poor compliance with internally and externally set standards on quality and safety resulting in patient harm or poor patient experience.
The Trust does not deliver the necessary improvements required to achieve full compliance with NHS England / Improvement resulting in enforcement action.
Failure to achieve local and national performance targets resulting in patient harm, poor patient experience or enforcement action.
Failure to maintain current estate and equipment and to develop a future estates model due to lack of available capital or resources resulting in patient harm, poor quality patient care or regulatory enforcement.
Not maintaining the Trust Care Quality Commission (CQC) overall rating of good and increasing the number of services achieving an outstanding rating due to failure to comply with regulatory standards resulting in a reduction of quality of services to patients and an impact on reputation.
Non-compliance with the Health and Safety at Work Act and regulations due to lack of clarity on roles resulting in harm to staff, patients, the public, visitors, potential regulatory failure and reputational damage.
Risk that services are unable to maintain current levels of Covid-19 capacity or respond to surges in Covid-19 demand and non-Covid-19 patients, non-elective, elective and urgent have delays to treatment due to limitations on capacity. Both risks may result in patient harm, loss of life and colleagues not being protected. There is also the potential for an adverse impact on health inequality.

A workforce for the future risks
Medical staffing - not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
Nursing staff - not being able to deliver safe and effective high quality care and experience for patients due to insufficient nursing staff caused by an inability to attract, recruit, retain, reward and develop colleagues.
Not attracting or retaining colleagues who are confident and competent to provide compassionate care to patients and compassionate and inclusive leadership to colleagues.
Risk of not appropriately engaging all colleagues across the Trust and a failure to embed the behaviours of the organisation due to a lack of robust engagement mechanisms.

Sustainability risks
The Trust will not secure sufficient capital funding to maintain facilities over the longer term and meet safety and regulatory standards resulting in patient harm and regulatory intervention.
The Trust will not deliver external growth for commercial ventures resulting in potential lost financial contribution.
Longer term financial sustainability of the Trust (as a going concern and providing value for money) due to the size of the underlying financial deficit and requirement for central funding support.
Climate action failure resulting in adverse impacts on public health, patients, natural environment, and reputation.

Financial sustainability

The financial context in which the Trust operates is challenging both in terms of the national economic picture and the local position. The Trust entered the pandemic with an underlying financial deficit position and this structural challenge remains, reflecting continued challenges of dual provision of services across two main sites, maintenance costs of ageing infrastructure and Private Finance Initiative contractual commitments. However, the system funding envelope and therefore the Trust income allocation has the previous level of Financial Recovery Funding which supported this position embedded within it for 2022/23, providing some security.

In 2022/23 the Trust will need to exit from Covid-19 costs alongside managing the resources required to address clinical activity backlogs and delivering an ambitious efficiency programme. The Trust is also planning to continue to invest in information technology, medical equipment and estate schemes including the hospital reconfiguration programme in 2021/22. The total capital expenditure is planned at circa £39m.

The plan is mindful of the collaborative work of the West Yorkshire Integrated Care System and West Yorkshire Association of Acute Trusts. New models of service delivery working with partners continue to be developed to deliver sustainable services in the future. The Trust's own plans for service reconfiguration aim to deliver clinical and financial sustainability in the longer term. The Trust received approval in 2019/20 of the Strategic Outline Case for reconfiguration and continues to progress the development against which circa £200m of capital funding has been supported by the West Yorkshire Integrated Care System and the Department of Health and Social Care.

Key issues and risks and opportunities for 2022/23

The Annual Governance Statement within the Accountability Report in this Annual Report provides details on the risks and challenges facing the Trust in 2022/23 including those arising from the management of the Covid-19 pandemic and recovery of services, as well as opportunities. A summary of these risks and opportunities is given below.

In brief, during 2022/23 challenges are expected in relation to the reduction in patient backlogs and the delivery of the recovery plan (particularly diagnostics and theatre capacity). There are risks to the health outcomes for patients waiting to receive care and treatment as a consequence of the Covid-19 pandemic, patient experience, particularly for emergency care, patient flow through the hospital and the health and social care system. Risks remain around the capacity, resilience and health and well-being of our workforce, financial sustainability, including exiting from Covid-19 costs and the need to identify significant efficiencies. The long term impact of Covid-19 infections on patients remains uncertain.

Opportunities include service transformation and progression of the service reconfiguration plans and capital investment across the two hospital sites and community, with the new Accident and Emergency Department at Huddersfield Royal Infirmary due for completion in 2023. In terms of clinical services, we will continue to support the development of a sustainable service for non-surgical oncology for West Yorkshire. We will progress our digital functionality and maturity as well as seek to become a leader in data aggregation and data intelligence to better serve our patients, staff and external stakeholders, using our data to prioritise care to reduce health inequalities amongst our communities and opportunities to work with our partners across the Kirklees and Calderdale places and with other organisations across the West Yorkshire Integrated Care System (ICS). There are also opportunities to continue to develop new and innovative ways of delivering services and continue our investment in the health and well-being of our workforce.

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 and not go out of business or liquidate its assets in the foreseeable future.

For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is evidence of going concern.

The Trust Board has assessed whether it is appropriate to prepare the accounts on a going concern basis in this context.

The following has been taken into account:

- The ongoing requirement for health services, such as those provided by the Trust, is set out in legislation including the Health Act and Health and Social Care Act
- The West Yorkshire Integrated Care System long-term plans incorporate the continued provision of the services provided by the Trust.
- The Trust has its own long-term plans, as outlined in the business case for reconfiguration of services which have the support of NHS England / NHS Improvement (NHS E/I).

Based on these indications the Directors believe that it remains appropriate to prepare the accounts on a going concern basis, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

Social, Community, Anti-Bribery and Human Rights

The Trust has strong links with local communities and has worked closely with a range of community, NHS and private providers throughout the year to ensure effective care was provided to residents whilst the pandemic continued. We are grateful for the support these providers and the independent sector have provided us to help deliver healthcare services to our communities during the year.

The Trust is committed to work with partners in Calderdale and Kirklees to generate social value benefits for our communities over and above the direct provision of health and care services. We do this by ensuring that our procurement, workforce, and estate plans maximise the impact of public expenditure to get the best possible outcomes for the local area and reaching out to the most vulnerable groups and communities that currently experience inequality.

Our aim is to increase economic capital through job creation, individual capital by supporting knowledge and skills development (e.g. training placements, in-reach to colleges / schools, apprenticeships), social capital through citizenship, volunteering, building confidence and trust in communities, environment capital supporting sustainability, achievement of net zero carbon, and state of the art built environment that creates pride and sense of wellbeing, identity Capital through confidence in using services and that services are culturally competent and intellectual capital providing an exemplar of innovation, solutions, partnerships – supporting local skills development and ambition and working with Huddersfield University.

The Trust has worked with the Social Value Portal to undertake local needs analysis and has developed a social value action plan that will enable the Trust to work with contractors and supply chain to target and measure the wider social value that could be generated by targeting of the creation of jobs, training and apprenticeships to support the most deprived groups and communities. This will enable the Reconfiguration Programme and associated estate investment to support recovery from the impact of Covid-19 and contribute to tackling economic and health inequalities and support action on climate change.

In line with our ambition to be an anchor institution and positively influence the health and well-being of our local communities, our Green Plan proposes a range of key aspirations to address socio-economic issues in and around our local areas. It identifies several targets which include a focus on sustainable procurement. Through this

objective the Trust will promote local sourcing and ethical purchases, ensuring that future Capital projects invest funds within our surrounding community. More broadly speaking targets for ethical procurement also reduce the risk of Modern Slavery / child labour and enforce fair employment standards within construction.

Engagement with our patients and the wider community continues to be of upmost importance to the Trust and contributes to our understanding of what people need and expect from the services we provide. Further information can be found in the partnership working and patient experience sections of the Accountability Report.

We have used a range of communication strategies including social media to liaise with our communities to raise awareness of the range of urgent and emergency care services available across the whole NHS to support their needs, encouraging patients to choose the most appropriate health service, given the pressures seen during the year on Accident and Emergency departments.

We continue to promote equality of service delivery and focus on the reduction of health inequalities in our communities - further information on this can be found in the performance analysis section.

In line with our ambition to be an anchor institution and positively influence the health and well-being of our local communities, our Green Plan proposes a range of key aspirations to address socio-economic issues in and around our local areas. It identifies several targets which include a focus on sustainable procurement. Through this objective the Trust will promote local sourcing and ethical purchases, ensuring that future Capital projects invest funds within our surrounding community. More broadly speaking targets for ethical procurement also reduce the risk of Modern Slavery / child labour and enforce fair employment standards within construction.

We are committed to support local employment through our Apprentice Strategy. We have supported apprentices to gain practical training “on the job” with study to gain job-specific skills. We currently have 81 clinical apprentices on the programme. All of those who have completed have been offered a substantive post at the Trust. Our Apprentice team supports the apprentices and were rated as a good provider during the year in our first OFSTED inspection.

We are committed to reduce our adverse impact on the environment and have progressed this considerably during the year with a strategic framework to address areas of concern relating to carbon reduction, air pollution, waste, governance, sustainable travel and sustainable procurement. You can find further information on this in the performance analysis section - environmental matters.

The Board of Directors conducts its business in an open and transparent way.

We are committed to the prevention of bribery as well as combatting fraud with relevant policies. We have a counter fraud specialist in place who investigates, as appropriate, any allegations of fraud, bribery or corruption supported by our Counter Fraud policy as well as a Fraud Champion. The activities to counter fraud are overseen by the Audit and Risk Committee.

Modern Slavery Act 2015

The Trust has a Board approved anti-slavery and human trafficking statement which is published on its website at www.cht.nhs.uk/publications.

Trust Charity

The Calderdale and Huddersfield NHS Foundation Trust Charity raises money to support and enhance services provided by the Trust within our two hospitals, across our communities and within patients own homes. It has also helped colleagues employed in the Trust to maintain their health and wellbeing. Thank you to all those who have donated - it is really appreciated. You can read more about our charity and the difference donations have made, charity events and our Imagination Appeal at https://www.chftcharity.co.uk/home or drop into the Charity office at the entrance at HRI to find out more.

Performance Analysis 2021/22

How we measure performance

CHFT is under enormous pressure to meet the healthcare needs of a growing and diverse population, alongside the ever-changing health landscape following the impact of the pandemic and the need for recovery and stabilisation, plus the changes to the external environment and new role of the Integrated Care System (ICS). The Trust provides hospital services to both Calderdale and Huddersfield and community services in Calderdale.

The Trust's performance against a range of national targets and standards is assessed and reported internally and externally. These measures include the regulatory measures of 4-hour emergency care standard; cancer referral targets; infection control standards; staffing levels as well as many other quantitative and qualitative standards including patient experience, workforce measures such as sickness and safety metrics including harm free care. This integrated approach to performance ensures all elements of care and service delivery are balanced.

At the heart of the Trust's refreshed Performance Management and Accountability Framework (PMAF) stands the Integrated Performance Report (IPR) which represents how we report to each Board meeting and relevant Board committees on a monthly basis and is the reference point for how our performance has progressed over time. CHFT is one of the highest achievers across regulatory standards, locally determined key performance indicators (KPIs) and its performance has contributed to the movement from 'Requires Improvement' to 'Good' following the last CQC inspection in 2018. These are excellent achievements but there is still the need to evolve particularly with the demanding strategy and objectives that CHFT has set for the next ten years.

The refreshed framework includes an update to the IPR and reference to data quality alongside the development of a single combined narrative that seeks to triangulate performance for greater Board assurance. This narrative is driven by the Deputy Directors sub-group and uses collective thinking to form the combined narrative needed to describe the Trust's current performance.

With a focus on measurement for improvement, the IPR now has a greater Statistical Process Control (SPC) format which better informs decision-making. There is further emphasis on outcome-based measures, and this ensures we get the highest impact improvements done in relation to patient and staff outcomes.

The IPR is provided to the Board, to support it in its role of holding Executive Directors to account for the Trust's performance. A formal Trust Board is held bi-monthly. The IPR is accompanied by the triangulation narrative.

This is informed by detailed review at a divisional and executive level prior to the Board meeting.

The monthly Integrated Performance Report is shared with all relevant Board Committees for their agendas.

Underpinning data quality assurance systems have significantly developed with continued improvements to the data quality systems and processes.

The Trust has in place policies to assure the Board on a range of issues to ensure quality care is provided to patients. Systems and processes are in place to assure data accuracy and validity into the Board ensuring there is robust ward to Board assurance on the quality of care we deliver. Policies and Standard Operating Procedures to this effect are reviewed on a regular basis.

Assurance that the performance data used within the Trust and reported by the Trust is of a high standard has been via the Trust Data Quality Board, which reports to the Audit and Risk Committee with escalation into a weekly meeting of Executive Directors as appropriate. A Data Quality Group, which meets 6-weekly and reports into the Data Quality Board, focuses on specific data quality measures from both a corporate and service position.

The Data Quality Policy relates to all areas of data produced by the Trust.

High quality data is a fundamental requirement for CHFT to conduct its business efficiently and effectively. It enables the delivery of the Trust's four pillars and is central to the Trust's on-going ability to meets its statutory, legal, financial and other contractual requirements.

Performance Management Framework

The PMAF supports the Trust's ambition to deliver outstanding, compassionate care to the communities we serve, through strengthening the Trust's approach to performance management and performance support alongside learning from performance. It aims to foster a culture of responsibility and accountability at all levels within the Trust. Members of staff need to know what is expected of them and what contribution they make to the success of the Trust.

The PMAF supports delivery of national standards and the Trust's quality, financial and operational objectives.

The objective of the framework is to ensure that information is available and triangulated which enables the Board of Directors and other key personnel to understand, monitor and assess the Trust's activities. Information must be timely, accurate and complete and follow the principles set out in the Trust's Information Governance and Data Quality Policies.

We must learn from our Performance – whether that is good and is setting the benchmark whereby we are open to others learning from us, or whether we need to improve and as a result need to carry out deep-dives or thematic reviews to understand our own failings and 'go see' where necessary, seeking out best practice. CHFT has always considered it a strength to learn from other organisations who may have found success through different approaches.

The fundamental existence of our framework is to provide assurance to Board members, both Executive and Non-Executive, our governors, our partners, our patients and the public who rely on our services. The pandemic has demonstrated the strength

of this organisation to respond in the most difficult circumstances and we now need to assure our key stakeholders through our response to recovery and sustainability that we can be relied upon to return to the pre-Covid high level of performance that we were consistently able to deliver.

The Trust has set out its strategy and objectives for the next five years which are reflected in the PMAF. These include:

- Recovery
- Prioritisation of work to reduce health inequalities
- Achievement of compliance with regulatory standards
- Achievement of an outstanding CQC rating.

Recovery

The Covid pandemic has given the NHS and its partners their biggest challenge of the past 70 years, shining a light on the most successful approaches to protecting health and treating disease. Vulnerable people need support that is joined up across local authorities, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face. Similarly, no hospital could rise to the challenge alone, and new pathways have rapidly developed across multiple providers that enable and protect capacity for urgent non-Covid care.

The significant challenges that face health and care as we recover from the pandemic make it even more important to have strong and thriving systems for the medium term. Important changes were driven by emergency response but must be hard-wired into our future working so that the gains of 2020 can endure. Examples of our programme of transformation based on learning from the pandemic include virtual appointments, direct assessment pathways and theatre productivity.

As a Trust and across the system we will continue to recover non-Covid services, in a way that reduces variation in access and outcomes concentrating on health inequalities.

Funding decisions are focussed on addressing treatment backlogs and long waits reflecting the principles and priorities agreed by the Board of Directors and based on reducing health inequalities. In addition, we will ensure we deliver improvements in productivity, continue with outpatient transformation and secure the agreed quality priorities.

Trust actions to reduce health inequalities

At CHFT we have always believed that everyone in our community deserves the opportunity to lead a healthy, happy life and our differences, our diversity should not lead to disadvantage. It is at the heart of what we do, delivering compassionate care to everyone.

But we also recognise that these same differences and the environment we are born into, grow, live, work and age all shape our prospects for good health. This in turn impacts on how we think, feel and act and shapes our mental health, physical health and wellbeing.

The health inequalities we all recognise have been greatly exacerbated by recent events - not only by the Covid pandemic itself but the subsequent economic impact on jobs and income. The picture is stark, and we must all take responsibility for the changes necessary to close the health inequalities gap. This section details prioritisation of work by the Trust to reduce health inequalities

Here at CHFT we know we cannot address this challenge alone, but we can demonstrate through our leadership and through our decisive actions that we can be part of building a solution.

Recognising our community leadership role, we have agreed a set of eight challenges:

1. Protect the most vulnerable from Covid
2. Restore NHS services inclusively
3. Develop digitally enabled care pathways in ways which increase inclusion
4. Accelerate preventative programmes which pro-actively engage those at risk of poor health outcomes
5. Particularly support those who suffer mental ill-health
6. Strengthen leadership and accountability
7. Ensure datasets are complete and timely
8. Collaborate locally in planning and delivering action

These challenges allow us to hold a mirror up to ourselves and challenge our current service models, our stabilisation and reset plans and the strategic case for change that is guiding our reconfiguration work.

Reflecting the scale and complexity of the challenge and our need to learn at pace, we set up a Health Inequalities Working Group. Its work is guided by four themes, each led by a senior director to help shape our response and disseminate any learning across our organisation and wider Health and Social care system in Calderdale and Huddersfield.

The four themes are:

- The external environment looking at how we connect with our communities and use this to inform our business-as-usual planning. Work is being taken forward to develop new ways of involving local communities to listen and understand their needs and co-produce responses to reduce inequalities.

- The lived experience, with an initial focus on families accessing our maternity service. A key element of our workplan is to gain an insight into the lived experiences of women and their families when using maternity services.

- Health inequalities data and how we use data to complement clinical prioritisation and our post Covid delivery model. By reviewing the waiting list data, we have been able to look more holistically at patient groups and individuals with a view to moving away from the traditional urgency profile, then chronological dating of patients to one where we may want to prioritise based on different risks factors. The three areas currently in focus are patients by index of multiple deprivation (IMD); patients with a learning disability and patients from a BAME background.

- The staff experience, ensuring we have a workforce that reflects our local population. It is essential that we have a workforce that reflects our population at all levels, that we are pro-active in the planning and support provided to colleagues and that this is reflective of individual needs. Delivering a workforce and organisational development programme around Health Inequalities, diversity and inclusion and ensuring equal opportunities for all.

We have also strengthened leadership and accountability around the health inequalities agenda holding a variety of development sessions with our Board and the Council of Governors. This has helped ensure that everyone understands the reality of the widening health inequalities both locally and on a national level. As well as receiving updates on the main workstreams, health inequalities continue to be a regular agenda item on a number of Trust-wide leadership forums, including the Board of Directors meetings.

Together with our system partners, we are proud to be viewed as a good practice example in the way we are addressing health inequalities and we have been approached by several organisations and systems to share learning.

We continue to connect with other Trusts and Integrated Care Systems nationally, sharing our work and experience in the delivery of a Health Inequalities guided recovery framework. Particular interest is evident around Learning Disabilities with CHFT increasingly viewed as a thought leader.

Partnership working: The Trust has continued to work closely with our health and care system partners and the communities we serve to better understand the challenges we face and develop actions that could support a reduction in inequalities experienced by groups like the homeless, asylum seekers or refugees who are often more frequent attendees of A&E. Further detail on this and other partnership working over the past year are given in the Partnership Working section of the Accountability Report.

Using our data to inform stabilisation and reset: A Health Inequalities Clinical Reference Group was established to inform and drive the stabilisation and reset agenda.

Learning Disability: The process for prioritisation of adult patients with a Learning Disability on surgical waiting lists has been embedded into surgical practice with new patients identified and dated as a priority. This has continued for children on the waiting list who also have a learning disability and continues to be rolled out.

Waiting Times: In relation to ensuring equitable waiting times across the wider Health Inequality agenda significant progress has been made in the management of patients.

Our initial focus has been on patients with a clinical priority of 2 - where treatment should take place within 30 days of prioritisation. Having established a worrying variation by ethnicity and IMD we prioritised managing out this variation as part of stabilisation and reset. We believe that by focusing on health inequalities it is possible to both reduce waiting lists but also to bring down average waiting times.

To support this key agenda, we have built on the excellent data capture of ethnicity and other Health inequalities data with an ever-evolving section in our business intelligence system Knowledge Portal+. Through this we can identify the patients who require access in line with the agreed priorities and monitor delivery of these.

The following datasets are already included for analysis:

- Inpatient and day case activity
- Outpatient appointments
- A&E attendances
- Inpatient and day case waiting lists over time
- Referral to treatment (RTT) waits over time
- Cancer referrals and waits
- Appointment Slot Issue activity (a waiting list of patients who have been unable to book their appointment through the NHS-E Referral system following a GP referral due to lack of clinic slots).

The Trust, in line with all other Trusts nationally, has a significant backlog of patients awaiting access to outpatient, diagnostic and inpatient services. For inpatients and a percentage of outpatients these have all been clinically reviewed and a priority status assigned that links to the optimal waiting time based on their clinical presentation. This data is now being incorporated into the Health Inequalities dashboard where we can then look at it through different lenses including:

- Patients with a learning disability
- By ethnicity
- By index of multiple deprivation
- By frailty score

By reviewing the waiting list data, we have been able to look more holistically at patient groups and individuals with a view to moving away from the traditional urgency profile, then chronological dating of patients to one where we may want to prioritise based on different risks factors.

In conjunction with the various service experts and leads we intend to develop this further to provide a resource to assist the Trust in identifying both areas of need in the locality and areas that may benefit from further study or analysis.

Equality, Diversity and Inclusion

Equality, diversity and inclusion activities and principles are fundamental to the Trust's work to improve the experience and health outcomes for everyone in its care. Details of work that has taken place across the Trust between January and December 2021 is published on the Equality and Diversity section of the Trust's website at: https://www.cht.nhs.uk and further information is given within the Staff Report within the Performance Report.

Community Matron, Sarah Wilson (left) and Jayne Duffy, Clinical Manager for District Nursing received great patient feedback for their work at Halifax's Gathering Place Homeless Shelter.

Programme of Deep-Dives

To improve assurance around performance and data quality there is a formal programme of deep-dives across the key performance indicators (KPIs) within the Integrated Performance Report (IPR). There are currently approximately 100 metrics across the Care Quality Commission (CQC) domains which are reported at each Board Committee.

The deep-dives provide the Board with assurance on KPIs that regularly achieve target (Green RAG rating) and an understanding of the challenges of those that are currently missing their target (Red RAG rating) with a focus on learning and improvement.

A 12-month programme has been established which is refreshed annually. Audits are reported to the Executive Board via the Data Quality Board on a bi-monthly basis with the green KPIs identified proactively based on previous performance and the reds identified on publication of the IPR.

Deep dives are further supported by the 'Go See' pillar, either for colleagues to visit areas under review to talk to colleagues or for visits by colleagues in those areas to learn from others either internally or externally.

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

The Integrated Performance Report includes renewed focus on:

- Recovery
- Quality priorities
- Triangulation between quality, workforce and finance
- Outcome based indicators

The Trust Integrated Board Report supports the work of various Board Committees. The quality domains are the focus of the Quality Committee, the workforce domains the focus of the Workforce Committee and the responsive, finance and efficiency domains are reported into Finance and Performance Committee which also looks at the overarching performance position. In addition, Divisional IPRs are also produced in a similar format which also show directorate level with current month and year to date indicators.

Recovery Framework

A separate area of the IPR is now dedicated to Recovery and Stabilisation. Moving forward it will include a trajectory for recovery of backlogs based on the agreed Board of Directors' principles and priorities. The modelling work for Outpatients, Inpatients and Diagnostics submitted as part of our annual planning for 2022/23 forms the basis of our trajectories and ensures that we are clear on what success looks like and can track it as part of our performance management of Recovery. Referral rates and how activity, both elective and non-elective, and capacity are managed will be crucial to our successful

delivery of this unprecedented task and CHFT's credibility in the eyes of our patients and stakeholders.

The production of the Divisional IPRs ensure the timely flow of information, prompt escalation and a 'golden thread' from ward to Board. Directors hold a bi-monthly Performance Review Meeting with each Division. These are the single point for all performance related discussions with Divisions allowing for the triangulation of the various domains.

This forum provides the Executive Team with the opportunity to gain assurance that Divisions are formally monitoring and managing all areas of performance, holding the Directorates to account for delivering all necessary corrective actions. The meetings provide a formal opportunity for Divisions to share successes, concerns, escalate risks and work through complex issues.

Divisional Performance Review Meetings are a focal point for all performance related discussions with Divisions allowing for the triangulation of the various domains and the avoidance of the interdependencies of decisions being missed causing further performance issues.

This forum provides the Executive Team with the opportunity to gain assurance that Divisions are formally monitoring and managing all areas of performance, holding the Directorates to account for delivering all necessary corrective actions. The meetings provide a formal opportunity for Divisions to share successes, concerns, escalate risks and work through complex issues.

The Divisional Performance Review Meetings enable robust discussions to take place on performance issues where assurance is a concern, with a focus on root causes and solutions (rather than symptoms). The required recovery plans, resources and support are agreed at the Performance Review Meetings and risks and issues are escalated to the Board, by exception, appropriately.

It is expected that a similar performance management framework is used within the Divisions for management of departments and services that covers the full set of domains.

All agendas include:

- A review of progress against the Divisional Strategy
- Good news
- Health Inequalities
- Quality priorities
- Risk profile
- Regulatory Standards including budgetary controls
- Wellbeing
- Recovery
- ICS partnership developments (internally and externally)

Areas of outstanding performance are highlighted through Divisional Performance Review Meetings and associated Committees including the Council of Governors forum.

The Performance Summary for March 2022 on page 48 shows a split by domain of Trust performance during 2021/22.

Our performance

Calderdale and Huddersfield Foundation Trust has an excellent track recording in the delivery of safe and timely access for patients across all pathways.

The Trust has continued to perform well in its key metrics during 2021/22 despite the Covid pandemic and unprecedented levels of attendances at both emergency departments (ED) at various times throughout the year. We still managed to maintain key cancer metrics whilst in strategic gold command and control with mitigations in place to keep the organisation safe for patients. Cancer performance has been excellent culminating in all key targets being achieved during March 2022. Nationally the Trust had the second-best performance for Cancer 62-day referral to treatment.

Although the Trust missed the Emergency Care 4-hour standard during 2021/22, it has benchmarked extremely well nationally when its two key metrics (Emergency Care and 62-day Cancer) are considered together. The Trust was placed second out of 109 acute organisations and continues to be one of the top performing large acute Trusts in the country.

The impact of high ED attendance rates and significant numbers of Covid cases particularly in the first quarter of the year and then again at Christmas led to some very challenging operational issues. Acuity/dependency of these patients was also an issue, and this led to deterioration in a number of performance metrics from September onwards. We began to see long waits in both emergency departments which was an extremely poor patient experience, and we knew that this would increase risk for patients in terms of outcomes.

During the Omicron variant there were significant numbers of Hospital Acquired Covid infections of patients due to the transmissibility of the variant, and as well as this there was a Norovirus outbreak which lasted approximately four weeks on one ward area, reducing patient flow within Frailty and Elderly Care and requiring some extra capacity areas to be kept open.

For long periods there were approximately 100 patients on the Transfer of Care list (patients fit for discharge) due to capacity issues in social care packages of care and discharge to assess beds. This was partly driving an increase in medical outliers and occupancy levels and meant using the discharge lounge at Huddersfield Royal Infirmary (HRI) and Ambulatory at Calderdale Royal Hospital (CRH) as inpatient ward areas.

This also impacted on our Recovery Programme where we were facing challenges with increasing capacity due to staffing issues in theatres and waiting list initiatives not having the full desired impact on the backlog.

At its peak over the Christmas period staff availability remained a key issue with a daily focus on maintaining safe care for patients through the deployment of registered and non-registered staff members.

We had concerns around the more varied complex needs of the younger demographic that we were seeing with long lengths of stay. These patients had different needs packages from the usual older patients that were previously more prevalent. We had seen the same pattern of younger patients in Acute Medical Units and recognised that these patients would be more resource intensive than the traditional aging population with social requirements and mental health needs that had resulted from deconditioning over the last two years.

As part of our Recovery Programme we began to refocus our capacity to those patients who were waiting to access care following the disruption of our elective programme.

This meant more focus on prioritisation, health equality and the wider patient experience with a reduction in variation within and across specialties.

We were in a position where we needed to consider our response to the ongoing Covid prevalence alongside the delayed access to treatment for patients on our waiting lists.

We have seen higher levels of patients waiting, and with a longer length of wait, than other Trusts in West Yorkshire and as a result we have looked into each specialty in greater detail to try and understand the reasons for these differences. The position was largely determined by our choices over 2020/21 in terms of opening to referrals, continuing with cancer activity and limiting elective activity.

For our Stroke patients gaining access to a Stroke bed within four hours deteriorated and the issues were multifaceted, from patients stepping down from stroke being unable to be discharged in a timely way to problems with CT scanners which impacted on both timeliness of patient scans and subsequent time of admission into the Stroke bed base.

Community services were also increasingly seeing more complex and acute presentation with impacts on wider anticipatory care and long term conditions management.

Our continued good performance against the key regulatory national targets in the face of significant challenges is shown in the table below. The Trust's performance is a reflection of the adoption of the four pillars approach across CHFT.

Trust performance against key national regulatory targets for 2021/22 is given below.

Table: Performance against key national regulatory targets for 2021/22

Indicator	Target	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Total time in Emergency Department (ED) under 4hrs	>=95%	86.98%	78.81%	75.30%	74.53%
% Diagnostic Waiting List Within 6 Weeks	>=99%	83.71%	88.43%	81.59%	80.78%
Referral to Treatment Time, % Incomplete Pathways <18 Weeks	>=92%	n/a*	n/a*	n/a*	n/a*
Cancer 2 week wait (all)	>=93%	98.38%	98.41%	98.61%	98.07%
Cancer 2 week wait Breast Symptomatic	>=93%	99.00%	98.79%	97.19%	95.12%
Cancer 31 days from diagnosis to first treatment	>=96%	98.76%	97.64%	97.77%	98.67%
Cancer 31 days for second or subsequent treatment – surgery	>=94%	99.02%	92.13%	96.49%	94.74%
Cancer 31 days for second or subsequent treatment – drug treatment	>=98%	100.00%	100.00%	100.00%	98.12%
Cancer 62 day wait for first treatment (urgent GP)	>=85%	92.23%	90.81%	90.79%	88.74%
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	>=90%	60.71%	41.76%	67.12%	77.36%

**The field-testing of the Elective Care Clinical Review of Standards (CRS) began on 1st August 2019 and is now being considered for change in 2022. During this time CHFT are one of 12 field-test Trusts who are not required to report compliance against the existing 18 Week RTT standard.*

Quality Outcomes

Quality Priorities 2021/2022

Quality Priorities are agreed each year to support the achievement of the long-term Quality Goals in our Trust Strategy. The Trust has three key quality priorities chosen by our membership and an additional seven focussed quality priorities. Examples of the implementation of actions from these are contained within the tables below. We also report progress against each quality priority to our Board at Board meetings and in the annual Quality Account which is published on our website at Annual Reports and Annual General Meeting - CHFT (cht.nhs.uk)

The Trust has focused on the following Quality Account Priorities during 2021/22 chosen by our membership:

1. **Recognition of Sepsis** - sepsis is caused when the body's immune system overreacts to infection. Rapid diagnosis and treatment are critical to survival. Sepsis is responsible for at least 44,000 deaths each year in the UK, and 14,000 of those fatalities are considered avoidable.

   Performance
   The Trust met the 50% target for the percentage of patients coded with sepsis that received all elements of the BUFALO bundle (blood cultures, urine output, fluids, antibiotic, lactate, oxygen). Whilst we did not meet the 80% target for administration of intravenous antibiotics in the Emergency Departments (EDs) of recognition of sepsis for the severely ill septic patient, this priority continues to be closely monitored with actions to increase compliance continuing, such as new devices being trialled to reduce preparation time for the antibiotics and sepsis champions in the Emergency Departments. Compliance with sepsis training has been reduced due to staffing shortages and vacancies. There are plans to make sepsis recognition and treatment part of essential safety training.

2. **Reduce number of Hospital Acquired Infections including Covid 19** - an estimated 300,000 patients a year in England acquire a healthcare associated infection (HCAI). This can impact on the health and well-being of patients, increase length of stay and pose a serious risk to patients, staff and visitors.

   Performance
   There were 27 Trust assigned C difficile infections in 2021/22. All cases are investigated as to whether they were preventable or unpreventable.

   There were 141 hospital onset Covid 19 infections (HOCI) during the year, reflecting a high level of Covid infections in the community and the high transmissibility of the Omicron variant. All probable and definite HOCIs were investigated following a process agreed with the divisions and the risk team. Any immediate learning is discussed at the Infection Prevention Control Gold meeting and communicated where relevant.

3. **Reduce waiting times for individuals attending Accident and Emergency (ED)** - being treated in a timely way in ED is important for both the experience and clinical outcomes of patients, particularly the elderly

   Performance
   The Trust is keen to reduce waiting times for individuals in the Accident and Emergency Department (ED) and information on 8 hour and 10 hour ED breaches is given below. As noted above the impact of high ED attendance rates and significant numbers of Covid cases particularly in the first quarter of the year and at Christmas led to some very challenging operational issues and unfortunately long waits for patients in both EDs. Much work has taken place within the EDs to ensure early escalation of lengthening waits for patients and this continues to be a priority for 2022/23.

Performance information relating for 2021/22 relating to the above three quality account priorities, which is reported to the Board in the Integrated Performance Report, is given below.

In addition, the Trust had seven other focused quality priorities across the Trust during 2021/22 which are detailed below, together with action taken during the year.

Further information on the above can be found in the 2021/22 Quality Accounts on our website on the Annual Report page (address given above).

The Annual Governance Statement in the Accountability Report provides further detail on the Trust's quality governance arrangements, including systems and processes in place to assure data accuracy and validity into the Board and how the Trust ensures data quality.

Quality Account Priorities 2022-2023

CQC Domain: Effectiveness	CQC Domain: Safety	CQC Domain: Experience
Recognition and timely treatment of Sepsis	**Reduce the number of Hospital Acquired Infections including COVID-19** 	**Reduce waiting times for individuals in the Emergency Department (ED)** 
Focus • Increase our concordance with the administration of intravenous antibiotics in the emergency departments within 60 minutes of recognition of sepsis to 80% for the severely septic patient. • Compliance of all elements of the sepsis 6 (BUFALO) to be improved to 50%. • Establish sepsis skills training as part of essential safety training and achieve 40% concordance for eligible staff in year 1. **Actions taken** Emergency Department consultant continuing to analyse red flag patient (sickest sepsis patients). Sepsis nurse providing increased training Additional sepsis trolleys available	**Focus:** • Implement patient testing strategies aligned to national guidance. • Support a system wide approach to the vaccination programme. • Review and implement the screening toolkit for Carbapenemase Producing Enterobacteriaceae (CPE), a type of bacteria or bugs that can infect the body • Reduce the number of preventable Clostridium Difficile infections. • Ensure strategies are in place to minimise Hospital Onset Covid-19 Infection. **Actions Taken** CHFT was compliant with the minimal national patient testing regime and included additional tests as part of our local guidance Lateral Flow Device (LFD) testing was in place as per national guidance for staff The Trust continued to update and adapt to the changing guidance in relation to patient visiting during the year. Virtual in Hospital Visiting continued to be offered by the Trust and endorsed by NHS England/Improvement The Trusts remains consistent in position that masks are required within the healthcare setting.	**Focus:** • Monitor the standard operating procedure within the emergency department to ensure timely escalation and prevention of patients remaining in the department longer than the national / local standards • Ensure lesson learnt are implemented where patients remained in department longer than national guidance. **Actions Taken** • capture any length of stay in ED over 12 hours • redesign of internal actions when there are signs of lengthening waits in ED and cascade of this to on-call management teams • new internal reporting format for 12-hour length of stay implemented to ensure consistency of data collection

Performance against our three Quality Account Priorities 2021/22

Quality Account Priority 1: Recognition and Timely Treatment of Sepsis

	Target	2021/22	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Percentage of adult patients that triggered in ED for red flag Sepsis that had antibiotics administered within 1 hour of trigger	**80%**	**50%**	61.9 %	51.4 %	53.6 %	53.8 %	37.8 %	50.0 %	52.5 %	46.8 %	52.5 %	42.0 %	48.8 %	46.8 %
BUFALO Bundle Total Compliance (%)	**50%**	**51%**	45.4 %	48.1 %	51.2 %	56.2 %	42.2 %	55.9 %	56.3 %	51.7 %	43.7 %	56.7 %	59.4 %	50.5 %

Quality Account Priority 2: Reduce number of Hospital Acquired Infections including COVID-19

	2021/22	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
Number of C Difficile Trust Assigned Infection	**27**	1	2	4	1	0	1	3	2	5	3	1	4
Number of Hospital Onset Covid Infection	**141**	2	4	0	0	2	6	12	3	5	66	12	29

Quality Account Priority 3: Reduce waiting times for individuals in the Emergency Department

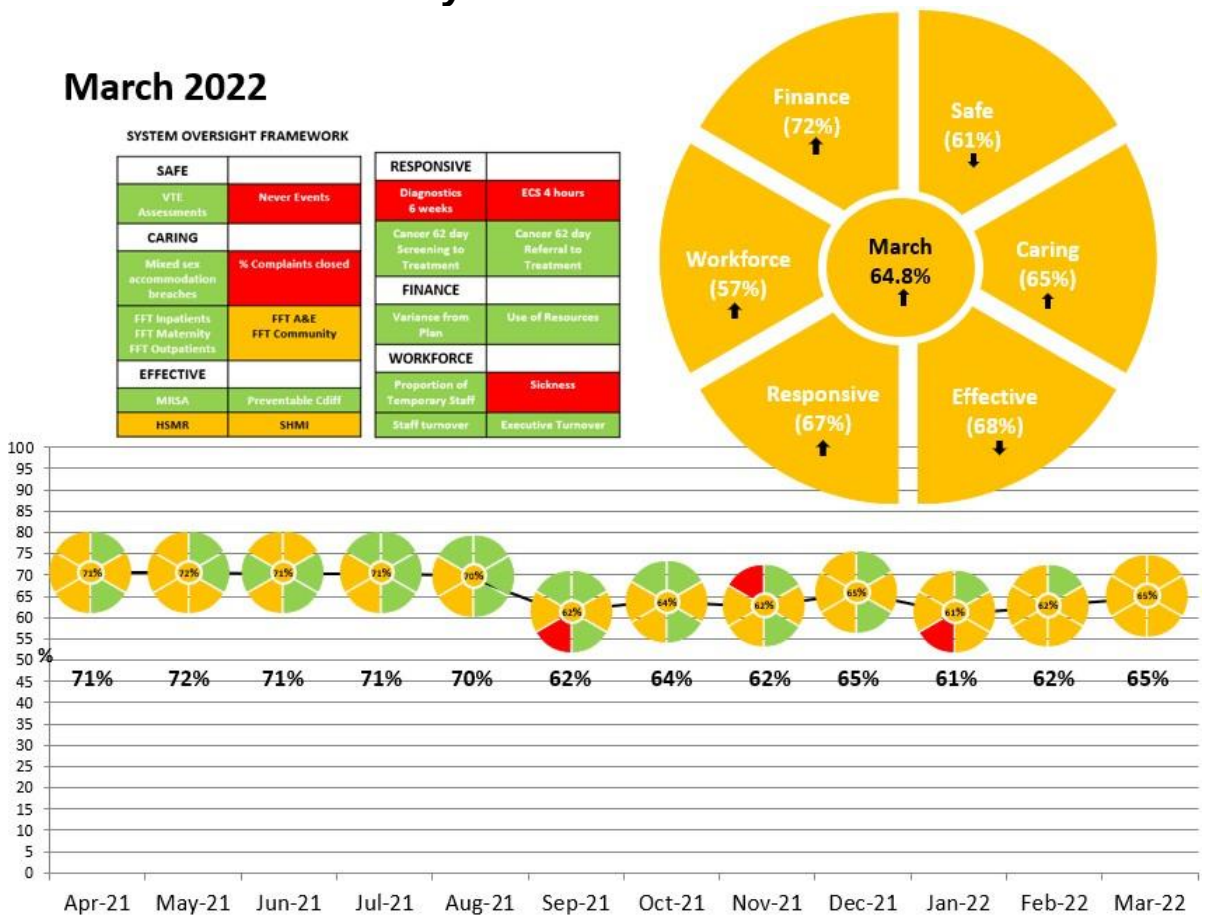
	2021/22	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22
No. of 8 Hour A&E Breaches	**10042**	277	303	312	791	746	850	1,233	965	1,258	1,146	1,006	1,155
No. of 10 Hour A&E Breaches	**4660**	101	102	108	316	319	382	596	443	659	606	492	536

Focused Quality Priorities 2021-2022

CQC Domain: Safe	CQC Domain: Caring	CQC Domain: Safe	CQC Domain: Responsive	CQC Domain: Safe & Caring	CQC Domain: Safe	CQC Domain: Responsive
Reducing the number of Falls resulting in harm	**End of Life Care**	**Increase the quality of clinical documentation across CHFT**	**Clinical Prioritisation (Deferred care pathways)**	**Nutrition and Hydration for in-patient adult and paediatric patients**	**Reduction in the number of CHFT acquired pressure ulcers**	**Making complaints count: Implementation of the national regulations & PHSO standards (phased introduction)**
Focus • Audit and embed changes proven to reduce the number of inpatient falls. • Implement the CQUINN targets for prevention of inpatient falls • Embed learning from serious incidents, produce bite size learning, • Develop workshops and strengthen the influence of falls link nurses.	**Focus** • Implement 7 day working across inpatient/ community services • Improve access to ePaCCs • Introduce a standard(s) that will improve a person's experience pre and post bereavement delivered by the ward teams • Review the Bereaved relatives telephone support service	**Focus** • Optimise the Clinical Record through: - In-depth analysis of the current process around electronic documentation - Benchmark - Set standards • Trial the use of the Digital White Board within the hospital setting in 2 designated areas • Review the Ward Assurance Tool within KP+ setting appropriate metrics • Assign responsibility to Ward Managers & Matrons to drive improvement in clinical documentation within their ward area • Ensure Ward Managers own their ward data using KP+	**Focus** • Ensuring known health inequality groupings are not disadvantaged as we recover and reset • Maintain compliance with the agreed clinical prioritisation process across the trust.	**Focus** • Provide safe and high-quality nutrition and hydration care that is aligned to National guidance and delivered by a Multidisciplinary team. • Provide healthy and nutritional foods, drinks, supplements and artificial feeds. • Nutritionally screen all patients and plan care accordingly using a person-centred approach. • Ensure nutrition and hydration care is delivered by a trained and competent workforce. • Develop ongoing monitoring and assessment processes to ensure high standards are	**Focus** • Support a system wide approach to pressure ulcer prevention and management • Strengthen clinical leadership at the frontline by empowering healthcare workers to provide exemplary care • Implement over-arching policy recommendations aligned to national guidance • Review, amend and implement new documentation processes on EPR • Engage, challenge, motivate and educate healthcare workers via a robust training programme	**Focus** • Fully align the work of the Making Complaints Collaborative to ensure it is delivering against the national complaints' regulations and the emergent PHSO standards. • Support a trust wide / user led approach to 'Making Complaints Count'. • Review existing processes, policy and operating procedures as needed to be assured of compliance and that operations are fully supported.

Actions Taken Falls prevention intervention care plans have been created and disseminated across the wards The Falls policy is being updated to reflect specific timeframes for assessments Patient and carer falls leaflet has been updated	**Actions Taken** 7-day service implemented across community services Increase skill mix to enable an increase in bereavement calls and also in reach into ward areas. Bereavement support service now work closely with the medical examiners team to prioritise relatives who they feel may need extra support	and to react to the quality therein • Audit clinical records using an agreed audit tool • Identify & establish a project team that can drive the improvement of data entry into EPR across the Trust • Ensure that training in the use of EPR reflects the standards laid down by the Trust and that it reflects the varying training needs of the staff **Actions Taken** Digital white boards have been produced. First trial area identified Ward assurance tool in place and divisions now monitoring compliance and improvements Training in use of Ward Assurance Tool rolled out to Managers and Matrons	**Actions Taken** Review of health inequalities data to compliment clinical prioritisation and our post COVID-19 delivery model for both planned and unplanned care A Clinical Reference Group on Health Inequalities established and meeting regularly to steer this element of recovery	maintained during meal service. Monitoring of nutritional intake and appropriate assistance is given to all vulnerable patient groups. **Actions Taken** CHFT Policies and guidance reviewed against NHS guidelines & NICE with updated guidance released Patients with additional nutritional needs are discussed daily in the ward safety huddles Observation of mealtimes during Observe and Act framework.	**Actions Taken** Joint work undertaken with BHFT in developing a new suite of pressure ulcer care plans Tissue Viability Nursing Associates continue to deliver bedside training to wards Guidelines for Documenting Individualised Care through EPR published and circulated to clinical areas	**Actions Taken** Equality monitoring data is now captured as part of the service user survey and at the point of access into the service. Complaints training has been reviewed. A revised training package to be developed and offered. All complaint responses have a quality assurance check

Performance Summary



Performance against our goals

The Performance Overview section detailed our Trust plan for key areas of delivery during 2021 - 2022 to support the achievement of each of the four goals of the Trust which are:

Transforming and improving patient care	Keeping the base safe	A workforce for the future	Sustainability

The Board received reports on progress against each of our objectives to achieve our goals during 2021/22.

The first of these was an update from April to September 2021 on the 2020/21 strategic plan with 14 of the 19 deliverables completed or on track, with those deliverables with ongoing work to progress by March 2022 into 2022/23 given below.

The Trust's progress with key objectives for the 18 month period November 2021 to March 2023 were reported to the Board in March 2022. 14 of the 19 deliverables were rated as either fully completed or on track to be completed with the remainder continuing to be progressed during 2022/23.

The objectives which were completed or on track at the end of March 2022 were:

- we have implemented a programme of transformation based on learning from the Covid-19 pandemic to deliver ‘Business Better than Usual’ - during 2022/23 this will be further progressed through the main annual planning and longer term strategic planning processes in the Trust
- Trust Board and NHS England / Improvement has approved the full business case for the new Accident and Emergency Department at Huddersfield Royal Infirmary and the Trust Board has approved the reconfiguration business case for Calderdale Royal Hospital
- we have continued to progress implementation of the Trust’s Clinical Strategy working with partner organisations across West Yorkshire
- Trust Board approval of a 5-year digital strategy supported by an agreed programme of work and milestones
- Involved patients and the public to influence decisions about their personal care fostering a learning culture and best practice to improve patient experience by responding to the needs of people from protected characteristics groups, implementing “Time to Care” and achieving patient safety metrics
- Delivered the actions in the Trust’s Health and Safety Plan
- Developed and implemented flexible recruitment and redeployment processes to improve our skill mix and improve our vacancy rate for nurse staffing and specialist medical roles, thus retaining a turnover below 10%.
- Developed an approach to talent management that further embeds our approach to succession planning, whilst maintaining fair and equal opportunities of employment, resulting in an increased number of internal promotions
- Revised our Leading One Culture of Care and Management Essentials programme to support managers to successfully lead their teams through Recovery and beyond
- Developed health and wellbeing support plans for all Departments to improve our health and wellbeing of colleagues, resulting in an improved health and wellbeing score in the annual staff survey
- Delivered the regulator approved financial plan
- Demonstrated improved performance against Use of Resources key metrics.
- Implement the Trust Board approved Green Plan demonstrating progress against the agreed action plan that will support reduction in the Trust’s carbon footprint
- Collaborated with partners across West Yorkshire and in place to deliver resilient system plans

With another 12 months to deliver the strategic objectives by March 2023, five of the deliverables were rated as amber as being ‘off-track’ at that point (i.e., slightly delayed) but with a clear plan for improvement in place. These areas that will be progressed in 2022/23 are:

- Use of population health data to inform actions to address health inequalities in the communities we serve.
- Stabilise the delivery of services in response to the Covid-19 pandemic to minimise the loss of life and protect colleagues’ safety
- Maintain the Trust CQC overall rating of ‘good’ and increase the number of services achieving an outstanding’ rating
- Work with system partners to achieve key performance metrics for urgent and emergency care and elective recovery.
- Develop an approach to inclusive recruitment panels and assessment processes to ensure a senior management team that reflects the diversity of our local communities.

During 2020/21 and 2021/22 the monitoring of the use of resources (UOR) score has been suspended by NHS England / NHS Improvement in recognition of the different operational and financial position driven by the Covid-19 pandemic. During the year we worked within the integrated care system financial regime and progressed key workstreams with our West Yorkshire acute hospital Trust partners.

The year-end financial performance from a regulatory perspective is shown below. The Trust Group successfully delivered a £37k surplus. This is an adjusted position from the 2021/22 annual accounts as certain accounting elements are excluded from the regulator's judgement of our performance.

Adjusted financial performance	**2021/22**	**2020/21**
	£000	**£000**
Surplus / (deficit) for the period	**(301)**	**(9,399)**
Remove net impairments not scoring to Departmental Expenditure Limit	318	12,670
Remove capital donations / grants I&E impact	(495)	(2,247)
Remove net impact of DHSC centrally procured inventories	410	(669)
Remove loss recognised on return of donated COVID assets to DHSC	113	-
Remove gains on disposal of assets	(7)	-
Adjusted financial performance surplus / (deficit)	**37**	**355**

In terms of digital technology, we continue to use technology to improve the way we care for our patients and have continued to improve on the digital functionality and maturity of the healthcare environment during the year.

CHFT is a leader in the use of digital technologies in the provision of healthcare across the UK and is seeking to be a leader in data aggregation and data intelligence in 2022/23 to better serve our patients, staff and external stakeholders. We will also work with our partners across the Integrated Care System to share data and improve patient pathways. Further detail on partnership working is given in the Accountability Report section.

During 2021/22 the Trust has been part of the national Digital Aspirant Programme, progressing a number of our digital ambitions to enable us to provide safe and efficient care. Further information on our digital strategy and ambitions can be found at: Executive Summary - CHFT (cht.nhs.uk)

Emma Burbidge with patient Stevie O'Connell

CHFT was the first to launch a new shared maternity electronic patient record system across West Yorkshire and Harrogate.

Environmental Matters

The Trust is keen to minimise its adverse impact on the environment and has in place clear and detailed plans on how it will contribute towards a "Greener NHS" and commit to delivering a Net Zero Health Service that drive sustainability at the Trust. The Board approved the Trust Green Plan in May 2021 which brings together these plans and reports to provide one overarching strategic document to govern and drive the sustainability agenda and ensure the Trust meets obligations for carbon reduction, adaptation reporting and resilience, in order to comply with the legislative requirements set out in the Climate Change Act 2008. The Green Plan provides a strategic framework to address areas of concern relating to carbon reduction, air pollution, waste, governance, sustainable travel and sustainable procurement at the Trust, as outlined in the 'Delivering a Net Zero Health Service' Greener NHS report. The strategy has been developed alongside an ambitious Sustainability Action Plan (SAP) and guarantees an integrated approach to sustainability which is aligned with clinical care models, resilience plans and our strategies for workforce engagement and corporate responsibility.

The SAP proposes numerous interventions to address carbon reduction objectives, whilst ensuring integration with the Trust's corporate objectives. The Green Planning Committee meets monthly to develop, promote and monitor the progress of the Green Plan and accompanying SAP, reporting to the Transformation Programme Board. As of March 2022, 74 of the 176 actions outlined in the SAP have been completed.

Our carbon baseline covers aspects of our operations which contribute to carbon dioxide equivalent (CO_2e) emissions including utilities consumption, waste arisings and disposal and anaesthetic gases. The Trust has seen significant carbon reductions in relation to our 2013 baseline. Between 2013 and 2018 total emissions have reduced by an estimated 31% and we have therefore successfully exceeded the Climate Change 2008 Act target of reducing our annual carbon footprint by 28% by 2020. This is the direct result of interventions such as a major LED lighting renewal scheme at Huddersfield Royal Infirmary (HRI) which saw the replacement of 6500 inefficient fittings, procurement of 100% renewable energy contracts and estate rationalisation to reduce gas usage as a result of heating. Our carbon impacts are measured annually and reported through Estates Returns Information Collection (ERIC)returns.

Further carbon reduction will be achieved via the Public Sector Decarbonisation Scheme (PSDS) which provides grants to public sector organisations to fund the implementation of heat decarbonisation and energy efficiency measures. The Trust has been successful in a bid for Low Carbon Skill Funding with our first funds received in January 2022 for work on the Trust's Heat Decarbonisation Plan. A second application for further PSDS funding has been submitted.

Sustainability is embedded into upcoming capital projects. All new clinical buildings will work towards BREEAM (Building Research Establishment Environmental Assessment Method) standards to ensure that sustainable design principles are considered. Our aim is to achieve a BREEAM rating of "excellent". Plans for the new Emergency Department at HRI include proposals for an air source heat pump system which would generate renewable energy onsite. Sustainable procurement plans are also being developed for both hospitals to encourage low carbon designs and responsible sourcing.

The CHFT Travel Plan was submitted to Board in 2021 as part of the Trust's plans for reconfiguration. The Plan aims to promote active travel and public transport and thus reduce single occupancy staff journeys across the next five years. Since adoption of the Travel Plan and accompanying action plan, 29 out of the 47 total actions have been completed. This includes improvements to cycle storage and electric vehicle charging infrastructure at HRI. Four Electric Vehicle Charging Points (EVCP) in the Acre Mill outpatient car park have been upgraded and a further review of electric charging provision across the site is currently underway to ensure adequate and additional EVCP capacity for staff and visitors. Additionally, CHS has introduced low/ultra-low emissions vehicles into its Transport and Estates fleet. As of April 2022, low/ultra-low emissions vehicles account for 93.75% of the CHS fleet- this exceeds the Green Plan target to convert 90% of our fleet to low/ ultra-low/ zero-emissions vehicles by 2028.

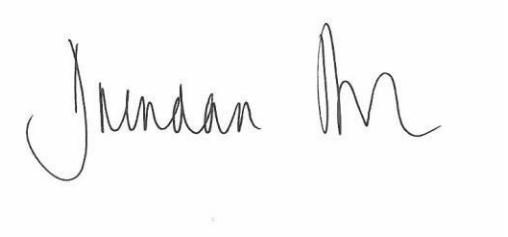
The Trust has implemented several measures to reduce clinical and non-clinical waste. As a result, the total carbon emissions attributed to waste arisings and disposal have reduced by approximately 17% since the baseline year. In clinical areas, the Trust has increased and promotes correct waste segregation and ensures zero to landfill via new waste contracts, ensuring clinical waste is dealt with locally. In non-clinical areas, CHS has increased the provision of recycling bins by removing individual bins under desks and providing a centralised recycling bin in each office. This is accompanied by information regarding the correct use of each bin, including what can and cannot be recycled. Additionally, the Trust plans to increase the repair and re-use of equipment where appropriate and has implemented campaigns to encourage recycling and reuse to limit the amount of waste generated.

Important events since the end of the financial year 2021/22

There are no important events to note since the end of the financial year 2021/22.

Overseas operations

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



Professor Brendan Brown
Chief Executive

5 July 2022

3. ACCOUNTABILITY REPORT

Directors' Report

Governance and Organisational Arrangements

The Directors' Report has been prepared under direction issued by NHS England / NHS Improvement, the independent regulator for Foundation Trusts, as required by Schedule 7 paragraph 26 of the NHS Act 2006.

The governance structure of all NHS Foundation Trusts include:

- Public and staff membership
- A Council of Governors
- A Board of Directors

The Trust is fully compliant with the requirements of the NHS Constitution.

Composition of the Board of Directors

The Board of Directors is a unitary Board and brings a wide range of experience and expertise to its stewardship of the Trust. The Board believes that it is balanced and complete in its composition with seven Non-Executive Directors and six Executive Directors with an appropriate balance of clinical, financial, business and management background and skills appropriate to the requirements of the organisation.

All the Non-Executive Directors are considered independent.

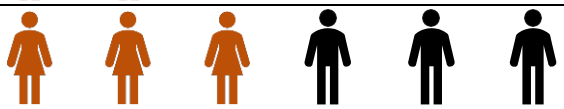
Responsibility for the appointment of the Chair and Non-Executive Directors resides with the Council of Governors and should it be necessary to remove either the Chair or any Non-Executive Director, this shall be undertaken by the Council of Governors in accordance with the Foundation Trust's Constitution.

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.

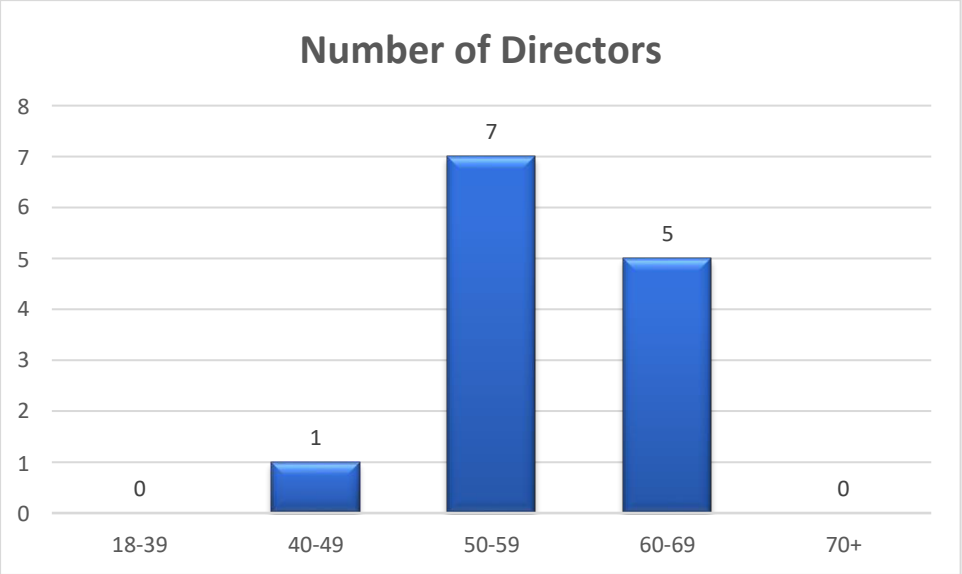
At the year end, the Board comprised the Chief Executive plus five Executive Directors, three non-voting Directors and seven Non-Executive Directors, including a Non-Executive Chair, ensuring the balance of power on the Board rests with the Non-Executive Directors.

Details of changes to Board membership are given below in the Directors section.

The gender balance of the Board of Directors as of 31 March 2022 was:

Non- Executive Directors	
Executive Directors	
Non-Voting Directors	

The age profile of the Board of Directors as at 31 March 2022 was:



Biographies of the Board of Directors

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

Professor Brendan Brown
Chief Executive
Appointed: January 2022
Professor Brendan Brown joined the Trust as Chief Executive in January 2022 after having spent three and a half years as Chief Executive at Airedale NHS Foundation Trust alongside his role of System Partnership Lead for the Airedale, Wharfedale and Craven Partnership.

He had previously held the position of Executive Director of Nursing/Deputy Chief Executive here at Calderdale & Huddersfield and at Burton Hospitals NHS Foundation Trust, and has previously held Board positions at Chief Nurse, Chief Operating Officer and Acting Chief Executive level. Brendan trained as a nurse in Derby and has a background in both acute hospital and community nursing senior management positions, with a proven track record for health and care leadership, and consistent improvements in the delivery of healthcare across hospital and community settings. He has a Masters with Distinction from the University of Nottingham.

Brendan is the Chief Executive Senior Responsible Officer for workforce across the West Yorkshire Integrated Care System, and was selected to participate in first cohort of The National Leadership Centre programme, a cabinet supported programme

developed to enhance the social and economic well-being of the country by supporting the leaders of public services to work together across the public sector system.

As Chief Executive and accountable officer, Brendan is responsible for the stewardship of the Foundation Trust, including developing an appropriate corporate strategy for Board approval and securing its timely and effective implementation. He provides leadership to the executive team and takes responsibility for the important external relationships with commissioners, regulators, local authorities, MPs and Government bodies.

Dr Owen Williams OBE
Chief Executive
Appointed: May 2012 - November 2021
Dr Owen Williams OBE has been the Chief Executive of Calderdale and Huddersfield NHS Foundation Trust since 2012 having consecutively served as the Chief Executive Officer of Rossendale District and Calderdale Metropolitan Borough Councils. In 2020 he was granted the degree of Doctor of Business Administration by the University of Huddersfield following the successful completion of his thesis which commenced 6 years previously in 2014. He was also invited by the Board of NHS England / NHS Improvement to Chair a National Task and Finish Group focused on addressing health inequalities in NHS provision and outcomes.

Prior to working in the Public Sector, he worked in commercial business including his first employment at the Yorkshire Building Society. He is passionate about reducing health inequality and ensuring that no communities - regardless of race, colour or creed - get left behind. Dr Owen Williams left the Trust in November 2021 to become Chief Executive of the Northern Care Alliance NHS Group.

Ellen Armistead
Executive Director of Nursing/Deputy Chief Executive
Appointed July 2019
Interim Chief Executive: November to December 2021

Ellen started her career in the NHS as a nursing auxiliary in elderly care settings. She has held a number of leadership positions across the country as both Chief Nurse and Chief Executive in acute and community services. Most recently Ellen was Deputy Chief Inspector of Hospitals with the Care Quality Commission.

Ellen’s passion is to ensure patients are at the heart of everything we do and the experiences of those in our care are continuously improving.

Ellen believes the key to providing care to the highest standards in terms of safety and outcomes is ensuring leaders at all levels are developed and empowered to lead with compassion for our patients and colleagues.

Jo Fawcus
Chief Operating Officer
Appointed: November 2021
Jo joined us on 7 November 2021 as our Chief Operating Officer having previously been in post as Chief Operating Officer at Northampton General Hospital and prior to that Chief Operating Officer at Kettering General Hospital for two and a half years.

Jo joined the NHS in 1995 and has worked in a number of systems having been Deputy Chief Operating Officer at James Paget Hospital in Norfolk and has also held several senior operational positions across the East Midlands.

Jo is really passionate about how we deliver high quality care to our patients, using leadership to influence change and create a positive culture. Jo believes the best way to achieve this is by us all working together to create a compassionate and inclusive work environment where we all feel we belong and can truly be ourselves, celebrating our diversity

Helen Barker
Chief Operating Officer
Appointed: January 2016 - October 2021
Helen joined the Trust substantively as Chief Operating Officer on 1 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. Helen retired in October 2021.

Dr David Birkenhead
Executive Medical Director
Appointed: June 2014
David has been working in the Trust as a Consultant Microbiologist since 1999. He has held a number of senior clinical leadership roles in the Trust and was appointed to the post of Interim Medical Director in June 2014 and then to a permanent post in July 2015. In addition to his medical degrees, David was awarded a Doctorate from the University of Manchester for his research into Campylobacter bacteria. As Medical Director, David shapes and leads the clinical services delivered by the Trust in order to drive the best health outcomes. He is also the Executive lead for Infection Control and the Trust's Director of Infection Prevention and Control.

Current large-scale projects include reviewing how the Trust delivers care across the community and the hospitals, the development of seven day services, and the ongoing implementation and development of an electronic patient record. He is the Medical Director lead for Pathology across West Yorkshire and Harrogate. The Medical Director provides a professional lead for medical staff and, as the Trust's Responsible Officer, makes recommendations to the General Medical Council around medical revalidation. David also takes the lead on education and training, research and development and infection control.

Gary Boothby
Executive Director of Finance
Appointed: November 2016
Gary Boothby has been Finance Director since November 2016. Previously he was the Deputy Director of Finance from March 2016. Gary joined the Trust from the Mid-Yorkshire Hospitals NHS Trust where he had been the Deputy Director of Finance. Gary has over 25 years NHS experience and is both a Chartered Management Accountant and a Chartered Public Finance Accountant.

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 clinical teams to deliver both patient improvements and financial efficiencies.

In addition to his role as Finance and Contracting lead, Gary also has responsibility for the Huddersfield Pharmaceuticals Service (HPS) and client relationships with Estates and Facilities partners across the Trust.

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

Alastair Graham
Non-Executive Director
Appointed: December 2017
Alastair is the Chair of Calderdale and Huddersfield Solutions, which is a wholly owned subsidiary of the Trust. He is also a member of the Trust's Transformation Programme Board and sits on the Research and Innovation Committee.

Until recently Alastair was the Director of Golden Lane Housing (GLH), a leading UK charity providing housing for over 1,700 people across England, Wales and Northern Ireland. Alastair has helped GLH to develop innovative new ways of enabling people with a learning disability to live and thrive as part of the mainstream community. Prior to this role, Alastair led one of the largest regeneration programmes in the north of England as Director of the Oldham Rochdale Housing Market Renewal Pathfinder. Alastair has also worked in housing in a variety of housing and support roles in London and in Buckinghamshire. Alastair has a degree, a Diploma in Management Studies and the Chartered Institute of Housing Professional Qualification. He has two sons and has lived in Calderdale for the past 26 years.

Karen Heaton
Non-Executive Director
Appointed: March 2016
Karen lives in Hade Edge, Holmfirth and was previously Director of Human Resources at the University of Manchester until her retirement in November 2021. She was responsible for developing and implementing people strategies to support the University's goal to be a world leading research led University by 2030.

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 of Human Resources for over 25 years and is very experienced in transformational change within complex organisations. Karen is a member of the CBI's employment and skills Board.

Karen has also served as a Non-Executive Director of One Manchester and Chair of the Remuneration Committee. 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 Committee at the Trust. Karen is also a member of the Trust's Quality Committee and Nominations and Remuneration Committee of the Board of Directors.

Richard Hopkin
Non-Executive Director
Appointed: March 2016
Richard Hopkin 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. Since 2011 he has worked extensively with Age UK on both a local and national level and, until recently, was a Non-Executive Director of a housing association, Derwent Living for several years. Richard has been the Senior Independent Non-Executive Director (SINED) and Deputy Chair since January 2020, chairs the Finance and Performance Committee and is a member of the Audit and Risk Committee, the Charitable Funds Committee and the Pharmacy Manufacturing Unit Board. Richard is married with two children.

Andy Nelson
Non-Executive Director
Appointed: October 2017
Andy is an experienced Technology and Business Transformation executive with a successful 30-year track record in Central Government, Management Consulting, Retail and Finance sectors. Key positions held include being the group executive with global responsibility for Strategy, IT and turnaround programmes at RSA Insurance and several large-scale Chief Information Officer (CIO) roles in the private and public sectors including HM Government CIO.

Within the Trust he chairs the Audit and Risk Committee and is a member of the Transformation Programme Board. He also chairs the Green Planning Committee, the Security and Resilience Governance Group and attends The Health Informatics Service Executive Board. He is a volunteer with the Princes Trust providing business mentoring to young people. He is married with three grown-up sons and has lived in Barkisland since 1996.

Peter Wilkinson
Non-Executive Director
Appointed October 2019
Peter is a Chartered Surveyor with significant executive level experience for over 30 years at both a Big4 consulting firm and Real Estate firm, where he was an equity partner. Peter has particular expertise in advising on the delivery of business transformation across property, infrastructure & capital projects, leading on programme and project management incorporating wider business teams and stakeholders for both public and private sector clients.

Peter's leadership of organisational wide transformation with solid and practical use of Managing Successful Programmes (MSP), PRINCE2 and Portfolio Management is especially useful as the Trust progresses with its large and complex Reconfiguration of Services at both Halifax and Huddersfield.

Peter currently has his own consultancy business, based in Holmfirth, and has a number of other Non-Executive Director roles and Consultancy commissions across the North of England. He is married with one son and has lived in Holmfirth for over 20 years.

Peter is the chair of the Transformation Programme Board, and attends Finance and Performance Committee, Charitable Funds Committee and Pennine Property Partnership Board.

Denise Sterling
Non-Executive Director
Appointed October 2019
Denise is an Occupational Therapist by profession with 38 years' experience within the NHS and has held a variety of clinical, managerial and professional leadership positions. Most recently until retirement she held the position of Head of Occupational Therapy at the Leeds Teaching Hospitals Trust.

Denise led on the delivery of a wide range of quality improvements in clinical practice with positive outcomes for patients. She believes it is essential that people work together for the best interests of patients and truly listen to patients and the communities served to understand what they need. Denise has worked closely with colleagues across health, social and voluntary sectors to develop and deliver patient-centred health and care services.

A member of the Royal College of Occupational Therapists, Denise has served as Council Member and Chair of the Equalities Committee. Denise has a special interest in education and in an advisory capacity supports local universities in the development and accreditation of undergraduate and post graduate programmes. She is also a Trustee and Chair of the Secondaries Committee for Bradford Diocesan Academies Trust.

Denise is the Chair of the Quality Committee and attends Audit and Risk Committee and Workforce Committee and chaired the Oversight Committee.

Nicola Seanor
Associate Non-Executive Director
Appointed: December 2021

Nicola is a Criminologist who currently heads up the Health and Justice service for NECS with over 20 years' experience within criminal justice / public sector and a background in Youth Offending Services, 'Looked after' young people, local government transformation and Health and Justice commissioning.

Nicola is an Associate Non-Executive Director at the Trust focused on the Quality agenda and Chairs the Patient Experience Group.

Meetings of the Board of Directors

The Board of Directors is responsible for exercising all the powers of the Foundation Trust and is the body that sets the strategic direction, allocates the Foundation Trust's resources and monitors its performance.

The Board has an annual schedule of business which ensures it focuses on its responsibilities and the long-term strategic direction of the Foundation Trust. It meets six times a year to conduct its business. The Board also meets six times a year to discuss matters requiring strategic debate and for training**.**

The Board of Directors met seven times during 2021/2022 including the Annual General Meeting. Board meetings were held remotely via digital technology following Government restrictions and NHS guidance on groups of people meeting in public. The Lead Governor was invited to each of the Public Board meetings to represent the Council of Governors and a number of publicly elected governors were invited on a rotation basis. The agenda and minutes have continued to be made available and published on the Trust website for all Board meetings held. The Board meetings have been recorded, with the recordings published on the Trust website.

Attendance at Board of Directors meetings

The attendance of members of the Board during 2021/2022 is given below:

Name	Role	Date Commenced in CHFT	Board of Director Meetings Attended
EXECUTIVE DIRECTORS			
Professor Brendan Brown	Chief Executive	04.01.22	2/2
Dr Owen Williams	Chief Executive	14.05.2012	5/5
Jo Fawcus	Chief Operating Officer	08.11.21	2/2
Helen Barker	Chief Operating Officer	01.01.2016	5/5
David Birkenhead	Executive Medical Director	01.12.1999	7/7
Gary Boothby	Executive Director of Finance	07.03.2016	6/7
Ellen Armistead	Executive Director of Nursing / Deputy Chief Executive	01.07.2019	7/7
Suzanne Dunkley	Executive Director of Workforce and Organisational Development	01.02.2018	7/7
NON-VOTING DIRECTORS			
Jim Rea	Managing Director – Digital Health	02.08.21	3/3
Mandy Griffin	Managing Director – Digital Health	19.01.2009	3/4
Anna Basford	Director of Transformation and Partnerships	15.07.2013	5/7

Stuart Sugarman	Managing Director – Calderdale and Huddersfield Solutions Limited	30.09.2019	7/7
NON-EXECUTIVE DIRECTORS			
Philip Lewer	Chair	01.04.2018	7/7
Richard Hopkin	Non-Executive Director / Senior Independent Non-Executive Director *	01.03.2016	6/7
Andy Nelson	Non-Executive Director / Chair of Audit and Risk Committee	01.10.2017	6/7
Alastair Graham	Non-Executive Director / Chair of Calderdale and Huddersfield Solutions Limited	01.12.2017	6/7
Karen Heaton	Non-Executive Director / Chair of Workforce Committee	01.03.2016	6/7
Denise Sterling	Non-Executive Director / Chair of Quality Committee	01.10.2019	5/7
Peter Wilkinson	Non-Executive Director / Chair of Transformation Project Board	01.10.2019	7/7

Declarations of Interest of Board of Directors

At each meeting of the Board of Directors a standing agenda item requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda and any changes to their declared interests.

The Trust holds a register detailing any interest declared by a member of the Board of Directors. The Board of Directors undertakes an annual review of this register of declared interests which details 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. There are no interests which may conflict with their management responsibilities as per the requirements of the NHS Improvement Code of Governance. The Chair declared he had no other significant commitments that affected his ability to carry out his duties to the full and was able to allow sufficient time to undertake those duties.

A copy of the register of declared interests for the Board of Directors is held by the Foundation Trust's Company Secretary and is available for public inspection on the Trust's website at www.cht.nhs.uk.

Committees of the Board of Directors

The Board of Directors has had six Committees during 2021/22. Two are required as set out in the Trust's Standing Orders:

- Nominations and Remuneration Committee of the Board of Directors

- Audit and Risk Committee

In addition, the Board has established four Committees to carry out detailed scrutiny and provide assurance on key areas of the Trust business:

- Quality Committee
- Finance and Performance Committee
- Workforce Committee
- Transformation Programme Board

Each Committee is chaired by a Non-Executive Director/independent member and is supported by Executive Directors and managers from across the Trust.

Details of the Nominations and Remunerations Committee of the Board of Directors can be found in the Remuneration Report section of this annual report. Information on the Audit and Risk Committee is detailed below and in the Annual Governance Statement. The Transformation Programme Board oversees and provides assurance on complex transformation programmes.

Information on the Quality Committee, Finance and Performance Committee and Workforce Committee can be found in the Annual Governance Statement within this Accountability Report.

The Trust continues to benefit from the receipt of charitable donations which are monitored and allocated separately through the Charitable Funds Committee. This Committee is chaired by the Trust Chair and reports to the Trust Board. We are extremely grateful to members of the public and local organisations for their support.

Audit and Risk Committee

The Audit and Risk Committee provides the Board of Directors with an independent review of financial and corporate governance and the 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 Board approved terms of reference which are reviewed annually. A self-assessment of the Committee's performance against the terms of reference is conducted annually and any actions for the forthcoming year identified to improve its effectiveness. Minutes and a highlight report appropriate are provided by the Committee Chair to the Trust Board following each meeting.

Membership of the Audit and Risk Committee for the financial year 2021/2022 was in line with good practice recommendations. The Committee met five times during the year, with a meeting in June which specifically reviewed and approved the Annual Report and Accounts with delegation from the Board of Directors.

Membership and attendance at the Committee for the financial year 2021/2022 is detailed below:

Audit and Risk Committee Membership and Attendance 2021/2022

Member	Meetings Attended Actual / Possible
Andy Nelson, Non-Executive Director Chair	4/5
Richard Hopkin, Senior Independent Non-Executive Director and Finance & Performance Committee Chair	4/5
Denise Sterling Non-Executive Director and Quality Committee Chair	5/5

Support for the Committee was provided by the Board Secretariat and meetings were regularly attended by the Executive Director of Finance, Deputy Director of Finance, Managing Director for Digital Health, Company Secretary, Internal Audit and Counter Fraud Service representatives from Audit Yorkshire and External Auditors, KPMG LLP (KPMG). Governors from the Council of Governors were also invited to attend and observe each meeting.

The duties of the Audit and Risk Committee are set out below.

To provide assurance to the Board based on review of the establishment and maintenance of an effective system of governance, risk management and internal control across the Trust's activities that support the achievement of the organisation's objectives. The Audit and Risk committee was assisted in this duty by:

- the Quality Committee, which has responsibility for providing assurance in relation to clinical quality and safety aspects
- the Risk Group, which reports into the Committee on risk
- the CQC and Compliance Group which reports into the Committee on compliance matters
- the Data Quality Board, the Health and Safety Committee and the Information Governance and Records Strategy Committee
- External audit, internal audit and counter fraud findings and performance

Deep dive presentations to the Committee from reporting groups, which included Data Quality, Health and Safety and Information Governance provided assurance about the effective functioning of these groups and current issues, supplementing routine reporting.

A deep dive on Risk Management, scheduled for January 2022 was deferred to the 2022/23 financial year due to operational pressures. The Committee reviewed the Risk Management and Strategy and reviewed, on a regular basis, the strategic risks described within the Trust's Board Assurance Framework. It also monitored the completion of an action plan in relation to access to clinical records.

The Committee reviewed the 2020/21 draft annual report and annual governance statement and signed off the annual report and accounts on behalf of the Board with delegated authority. It also received reports on topics including clinical audit, car parking strategy and controls, access to clinical records, internal audit, and counter fraud performance.

In terms of financial reporting, the Committee reviewed, with both management and the external auditor, the annual financial statements to determine their completeness, objectivity, integrity and accuracy. In addition, the review covered 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 and material areas in which significant judgements have been applied or there has been discussion with the external auditor. The Committee considered significant risks to the audit opinion highlighted by external auditors via their risk assessment in relation to the audit plan. The Committee received and supported a paper from the Director of Finance detailing the evidence to support the preparation of the financial statements of the Trust on a going concern basis. The auditors provided the required reports on the financial statements and the Trust's value for money arrangements.

The Committee also reviewed the standing orders, standing financial instructions and scheme of delegation and other financial matters such as losses and special payments and standing order waivers. The temporary changes to financial governance and delegation, in place at the start of the financial year due to the Covid-19 pandemic, were revoked in January 2022.

The Audit and Risk Committee is authorised by the Board of Directors to investigate any activity within its terms of reference and to seek any information it requires from staff. In carrying out its work the Committee relies primarily on the work of the internal and external auditors. Last year, the Committee approved the internal audit, counter fraud and external audit work plans and received regular reports.

The external audit service is provided by KPMG. External auditors attended the Committee regularly, providing an opportunity for the Committee to assess their effectiveness. The Committee reviewed, approved and monitored the External Audit plan for 2021/22 to gain assurance of the quality and effectiveness of the service received from KPMG. The fee for the audit was £177K.

The Committee oversaw the process for the appointment of external auditors. External auditors were re-appointed in November 2021 for a period of three years, with the option of a one year extension, following a procurement process involving governors in line with national guidance and approval by the Council of Governors. The external audit provider KPMG was not commissioned by the Trust during the year to undertake any significant non-audit work.

The internal audit and counter fraud service provided by Audit Yorkshire meets mandatory NHS Internal Audit standards and provides appropriate independent assurance to the Audit and Risk Committee. The Committee considered the major findings of internal audit work and the management response to them. Further detail on the audits and audit opinions undertaken during the year is provided in the Annual Governance Statement.

In monitoring progress with the annual plan, the Committee noted that in some areas it was a challenge to progress elements of the plan due to the Omicron variant of Covid-19 pandemic impacting on the availability of Trust staff for the audits. Assurance was sought that the key audit work for completion within the plan would be undertaken in a timely way. The Committee received regular progress reports from internal audit enabling it to monitor progress by management with agreed actions from internal audits,

with completion of recommendations from previous years continuing to be closely reviewed by the Committee.

The Committee maintains an oversight function for expressions of concern, with the counter fraud specialist attending the Committee to highlight in confidence any concerns about possible improprieties in matters of financial reporting and control. The Trust Freedom to Speak Up Guardian and ambassadors encourage staff to speak up about matters of clinical quality, patient safety or other matters of concern and report on these to the Workforce Committee and the Board.

Jovial Man unveiling

Dr Paul Knight, Organ donation lead and Jayne Greenhalgh, Specialist Nurse Organ Donation officially open the statue donated by the family of Grenville Stacey.

Compliance with 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 Board of Directors has established governance policies that reflect the principles of the NHS Foundation Trust Code of Governance. These include:

- Standing Orders of the Board of Directors
- Standing Financial Instructions
- Scheme of Reservation and Delegation
- Constitution.
- Terms of reference of the committees and sub-committees of the Board of Directors and Council of Governors
- Robust Audit and Risk Committee arrangements
- Going Concern Report
- Annual business cycle of the Board of Directors and its Committees
- Role description and appointment of Senior Independent Director
- Well-led Governance Review report
- Board of Directors skills and capabilities competency assessment
- Integrated Performance Report
- Provision of high quality reports for the Board of Directors and Council of Governors
- Board and Committee reports and supporting minutes
- Attendance records for Directors and Governors at key meetings
- Register of Interests for Directors, Governors and senior staff
- Annual declaration of compliance with the “fit and proper” persons test described in the provider licence for the Board of Directors and Governors
- Freedom to Speak Up: Raising Concerns Policy
- Fraud, Bribery and Corruption Policy
- Non-Executive Director candidate information pack and formal induction programme
- Nominations and Remuneration Committee for Executive Directors
- Regular private meetings between the Chair and Non-Executive Directors
- Performance appraisal process for the Chair and Non-Executive Directors approved by the Council of Governors
- Standing Orders of the Council of Governors
- Nominations and Remuneration Committee of the Council of Governors for Non-Executive Directors
- Non-Executive Director recruitment process
- Council of Governors Charter
- Dispute resolution procedure between the Council of Governors and Board of Directors
- Lead Governor role
- Monthly meeting between Chair and Lead Governor to review matters discussed at the Board of Directors
- Council of Governors agenda setting process
- Collective evaluation of the Council of Governors

- Council of Governors presentation of performance at the Annual General Meeting
- Governor led process for the appointment of the External Auditor
- Membership and Engagement Strategy
- Governor's Recruitment Pack
- Comprehensive Induction Programme for Governors
- Policy for the expulsion of Governors

The Audit and Risk Committee conducts an annual review of the Code of Governance, monitors compliance and identifies areas for further development.

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, six Non-Executive Directors, and six Executive Directors.

The biographies of the members of the Board can be found on page xx. During 2021/22 there were the following changes to the membership of the Board:

- Chief Executive - departure in November 2021 with the new Chief Executive in post from January 2022, with the Deputy Chief Executive as the Interim Chief Executive in the interim
- Chief Operating Officer - departure in October 2021, with the new Chief Operating Officer commencing in November 2021, with the Deputy Chief Operating Officer covering this role in the interim period

The Trust agreed to pilot a development role of an Associate Non-Executive Director role and appointed to this in December 2021. This is a non-voting role.

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 six times a year so that it can regularly discharge its duties.

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.

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/NHS Improvement, the Department of Health and Social Care and the Care Quality Commission.

Governance Arrangements
The Trust's Constitution was ratified in 2006 on authorisation as a Foundation Trust. Further changes have been made as required by changes in legislation and governance practice. The latest version of the Constitution is available on the Trust's website.

The Trust complies with its Constitution, requirements set by NHS Improvement, and relevant statutory and contractual obligations The Board has approved Standing Financial Instructions and a Scheme of Delegation and Reservation of Powers which outline the decisions that must be taken by the Board and the decisions that are

delegated to the management of the Trust. These documents include instructions on budgetary control, banking arrangements, contracts and tendering procedures, capital investment and security of the Trust's property and data, delegated approval limits, annual accounts and reports, payroll, borrowing and investment, fraud and corruption, risk management and insurance. Amendments to these documents were approved in year to support the management of the Covid-19 pandemic.

The Board has direct access to the advice and services of a Company Secretary who is responsible for ensuring that the Board and Committee procedures are followed, and that sufficient information and resources are made available for them to undertake their duties. The Secretary is also responsible for advising the Board, through the Chair on all corporate governance matters.

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.

Periodically and as part of succession planning, the skills and knowledge of the Board are assessed to satisfy the Board that it is fit for purpose and to inform recruitment processes to ensure that any gaps in knowledge that arise at short notice, or can be predicted through turnover, are filled.

Directors' Remuneration

The Non-Executive Directors, through the Nominations and Remuneration Committee of the Board of Directors, fulfil their responsibility for determining appropriate levels of remuneration of Executive Directors. The Committee is provided with benchmark data to support the decisions being made about the level of remuneration for the Executive Directors. More details about the Nominations and Remuneration Committee can be found on page 95.

Non-Executive Director Appointments

The appointment of the Chair, Non-Executive Directors and Associate Non-Executive Director forms part of the information included in the standing orders written for the Council of Governors.

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. The Chair is a Non-Executive Director who chairs both the Board and the Council of Governors.

The Senior Independent Non-Executive Director

The Senior Independent Non-Executive Director (SINED) provides an alternative route for communication with Governors if they feel unable to raise a particular concern through the Chair. The Senior Independent Non-Executive Director also undertakes the Chair's appraisal using a process agreed by the Council of Governors, after seeking feedback from the rest of the Board, and from Governors and partners.

Non-Executive Director Appraisal

Each year the Chair and Non-Executive Directors receive an appraisal, the outcome of which is reviewed by the Council of Governors.

The Chair appraises the performance of Non-Executive Directors using an agreed process with a programme of appraisals run during 2021/22. This includes seeking the views of governors on Non-Executive Directors to assess their independence and contribution to the Board of Directors and confirm that they are all effective independent Non-Executive Directors.

Governors
The role of the Council of Governors is:

- Appointment or removal of the Chair and other Non-Executive Directors
- Approval of the appointment (by Non-Executive Directors) of the Chief Executive
- Deciding the remuneration, allowances and other terms and conditions of office of Non- Executive Directors
- Appointment or removal of the Foundation Trust's external auditors
- Review and development of the Trust's membership strategy

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

The Council of Governors consists of elected and appointed governors. More than half are public governors elected by community members of the Trust.

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

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

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

A robust annual appraisal process is in place for all Board members and other senior Executives. The Chair undertakes an appraisal of the Chief Executive, and the Chief Executive undertakes the appraisal of the other Executive Directors against objectives. The Chair provides the Chief Executive with his view of the Executive Directors' performance in the Board meeting.

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

evaluation annually from December 2022 following feedback from a well-led governance development review.

The monitoring of progress of remaining actions from the CQC Well Led and Use of Resources inspections in 2018 was via a CQC action plan, the CQC and Compliance Group and the Board.

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

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

The Board of Directors promotes effective communications between itself and the Council of Governors. The Board, through the Chief Executive and the Chair, provide regular updates to the Council of Governors on the developments being undertaken in the Trust. The Board encourages the governors to raise questions and concerns during the year and ask for further discussions at their public meetings where they feel further detail is required. The Chief Executive and any invited director or Non-Executive Director will ensure that the Governors are provided with any information when the financial standing of the Trust has materially changed or the performance of its business has changed 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.

Where there is a dispute between the Board and Council of Governors, in the first instance the Chair of the Trust would endeavour to resolve the dispute. If the Chair is not willing or able to resolve the dispute, the Senior Independent Director and the lead governor of the Council of Governors would jointly attempt to resolve the dispute. The Council of Governors also has access to the Senior Independent Non-Executive Director should there be any concerns which cannot be resolved with the Board in the course of normal business.

In the event of the Senior Independent Non-Executive Director and the lead governor 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.

The Council of Governors has agreed clear and fair processes for the removal of any governor who fails to carry out their duties appropriately.

Understanding the views of the Council of Governors and members

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

Board balance, completeness and appropriateness

As at year ending 31 March 2022 the Board of Directors for Calderdale and Huddersfield NHS Foundation Trust comprised of six Executive Directors, six independent Non-Executive Directors and an independent Non-Executive Chair.

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

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

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

All Board members have confirmed that they do not hold any additional interests that are not declared in the Trust's Declaration of Interests.

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

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 page 66.

Attendance of Non-Executive Directors at the Meetings of the Council of Governors
All Non-Executive Directors have an open invitation to attend the Council of Governors' meetings. In addition, Non-Executive Directors are required to attend on a rotational basis. The Trust has also held joint Board of Directors and Council of Governors' workshops during the year which focussed on the development of strategy and the performance of the Trust.

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

Directors' remuneration
The Nominations and Remuneration Committee for Board of Directors 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 pages 95-96. The Council of Governors has a Nominations and Remuneration Committee which meets as required during the year. Part of the role of this Committee is to review the remuneration of the Non-Executive Directors. Details of the Council of Governors Nominations and Remuneration Committee can be found on page 93.

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 page 64.

Vaccination Programme

Thanks to the Covid vaccination team which gave almost 50,000 jabs to local people, working with our partners.

Care Quality Commission Registration

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

CQC carried out an inspection of the Trust in March 2018. The Trust was rated as good overall.

Well-led at Trust level was inspected in a separate inspection in April 2018. The Trust was rated as good for well-led. Use of resources was rated as requires improvement due to the Trust's underlying deficit.

The combined rating for quality and use of resources is good. A summary of the domain ratings is given below, comparing this with those of the previous inspection.

The Trust achieved:

- 'Requires improvement' for the safe domain.
- 'Good' for all other core service areas.
- 'Requires improvement' for the Use of Resources inspection.

Reports from the CQC inspection were published on their website in June 2018 and can be found at the following link: https://www.cqc.org.uk/provider/RWY.

Following the inspection in 2018, the Trust developed an improvement action plan to address all must-do and should-do recommendations. Governance of the action plan is through the CQC Compliance Group which has continued to meet, is chaired by the Executive Director of Nursing/Deputy Chief Executive and reports to Board through the Quality Committee.
The present position in relation to the CQC action plan compliance can be seen below:

CQC Exception Plan- Outstanding Action	Progress
Must Do 1 – The Trust must improve its financial performance to ensure services are sustainable in the future	A full round up of all the actions undertaken to support the Trust's Use of Resources (UOR) position was received by Finance and Performance Committee in early 2021/22. Consideration was also given to closure of this action given the successful delivery of an improved financial position in line with targets over several years and the progress made to advance the reconfiguration. However, given the scale of the challenge for 2022/23 a decision was made to keep the action open to ensure this has optimum ongoing monitoring and oversight.

The pandemic has changed the way in which CQC regulates providers. There is no longer a set inspection plan that would mean organisations have an onsite inspection on an annual basis.

The Trust has and continues to comply with the CQCs revised approach to regulation in line with the development of their future strategy.

This involves regular engagement meetings with the Trust's CQC Relationship and Inspection Manager and when requested, following the Transitional Monitoring Approach, which includes:

- A strengthened approach to monitoring, based on specific existing key lines of enquiry (KLOE), so they can continually monitor risk in a service
- Using technology and local relationships to have better direct contact with people who are using services, their families, and colleagues in services
- Targeting inspection activity where we have concerns
- Inspecting services as part of the wider Integrated Care System (ICS)

A new strategy for the changing world of health and social care, which was published in May 2021. This sets out how CQC will regulate providers in the future particularly focusing on four key themes:

- **People and communities**: Regulation that's driven by people's needs and experiences, focusing on what's important to people and communities when they access, use, and move between services
- **Smarter regulation**: Smarter, more dynamic, and flexible regulation that provides up-to-date and high-quality information and ratings, easier ways of working with us and a more proportionate response
- **Safety through learning**: Regulating for stronger safety cultures across health and care, prioritising learning and improvement and collaborating to value everyone's perspectives
- **Accelerating improvement**: Enabling health and care services and local systems to access support to help improve the quality of care where it's needed most

The Trust will be guided by the roll out of the CQCs new strategy, which is expected to be completed by summer 2023.

The Trust continues to undertake a programme of CQC preparation workstreams including the rolling programme of Journey to Outstanding Reviews at ward, service and departmental level to ensure the Trust is compliant with the required standards of care for our patients.

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. 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. Sustained performance improvement has been seen during the course of 2021/22 as seen in the cumulative annual data below.

Better Payment Practice Code – 2021/22						
Paid to	**Total Invoices Paid - Volume**	**No Invoices Paid on Time - Volume**	**% Paid within target**	**Total Invoices Paid - £**	**Value Paid on Time**	**% £ Paid within target**
Non - NHS Organisations	**66,073**	**62,084**	**93.96%**	**£194.0m**	**£178.8 m**	**92.14%**
NHS - Organisations	**1,226**	**1,121**	**91.44%**	**£28.2m**	**£27.5m**	**97.54%**

Better Payment Practice Code - 2020/21						
Paid to	**Total Invoices Paid - Volume**	**No Invoices Paid on Time - Volume**	**% Paid within target**	**Total Invoices Paid - £**	**Value Paid on Time**	**% £ paid within target**
Non - NHS Organisations	**64,976**	**57,912**	**89.13%**	**£180.8m**	**£161.3m**	**89.23%**
NHS - Organisations	**1,390**	**1,094**	**78.71%**	**£29.4m**	**£28.2m**	**96.02%**

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. Note 6.1 to the accounts confirms that the Trust does not have income from fees and charges where the full cost exceeds £1m.

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 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, at Section 4 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).

Partnership Working

During 2021/22 CHFT has continued to work in partnership at local and regional level to ensure the very best services for the populations we serve in Calderdale, Kirklees and across West Yorkshire.

CHFT is a member of the West Yorkshire Health and Care Partnership (Integrated Care System) that brings together NHS organisations, councils, Healthwatch, hospices, the community voluntary social enterprise sector and communities to improve the health and wellbeing of the 2.4million people that live in West Yorkshire.

The Trust is also a member of the West Yorkshire Association of Acute Trusts (WYAAT). This is a collaboration of six NHS trusts who deliver acute hospital services across West Yorkshire and Harrogate. The aim of WYAAT is to provide region-wide efficient and sustainable healthcare that uses innovation and best practice to benefit patients. By working together, we aim to ensure the best possible experience and outcomes for patients and communities.

During 2021/22 the NHS Health and Care Bill describing legislative changes to strengthen collaboration and integration across health and social care has been progressing through parliamentary stages of approval with expected implementation in July 2022.

During the past year the Trust has worked closely with local place based partners in Calderdale and Kirklees to develop the plans for establishing place based committees of the West Yorkshire Integrated Care Board. The Trust is an active member of the Health and Wellbeing Boards in Calderdale and Kirklees that agree the health and wellbeing strategy in each place. Subject to parliamentary approval of the proposed legislative changes most of the decisions about spending and services will continue to be made in local places through these place-based partnerships. This work will feed into the West Yorkshire Integrated Care Board.

During 2021-22 the Trust has recognised the important opportunity, and further developed plans and actions to positively contribute to the broader health and wellbeing of Calderdale and Kirklees communities, supporting recovery from the pandemic by generating social value, economic and environmental benefits (e.g. local jobs, apprenticeships, training, addressing health inequalities and reduction in carbon use and emissions).

Some Examples of Our Partnership Working in 2021/22

<u>Reducing Health Inequalities</u>

- The Trust has worked with Calderdale Council and local system Partners to engage staff, communities, private and Voluntary and Community Sector (VCS) to address inequality during the pandemic, focusing on groups that have been impacted the

most. A video describing this work and implementation of the agreed action plan can be seen at https://youtu.be/cTGm9_5Gqlo

- Work was undertaken to review A&E attendances and admissions of people that are homeless, asylum seekers, refugees and high intensity users. This included hearing the lived experiences from refugees and asylum seekers facilitated by the St Augustine's Centre in Calderdale and the Resettlement Team in Kirklees. This learning has also been shared with the ICS to support their aim to become an ICS of Sanctuary. The actions suggested from the audit along with the user experience stories to improve the support available in the community has received funding from the ICS to develop a pilot project to create and implement Adversity Trauma Care Navigator roles in both our A&E departments. This pilot is being developed collaboratively between the ICS and the Trust, along with wider health and care system and VCS partners.

 The Trust continues to work in partnership with Primary Care to identify and reduce inequalities in emergency asthma admissions to hospital. Working with Primary Care colleagues, Locala and Kirklees Council Public Health team collaborative next steps and a joint action plan has been developed.

Providing Mutual Aid across Hospitals to Support Service Resilience

 During 2021/22 we have worked collaboratively to provide mutual aid across West Yorkshire along with other acute trusts. The Trust has provided support in the provision of general surgery services to Leeds Teaching Hospitals and non-surgical medical oncology services to Mid Yorkshire Hospitals NHS Trust. They in turn have supported us with the provision of maxillofacial services support.

Developing Plans for future Hospital Configuration and Estate Development

 The Trust has worked in partnership with the ICS, NHS England and local system partners to further develop our long term plans for hospital service reconfiguration. During 2021/22 we have involved local stakeholders and residents to inform our estate design proposals for construction of additional wards, theatres and a new A&E at Calderdale Royal Hospital and a new A&E at Huddersfield Royal Infirmary.

Improving Access to Outpatient Services

 With over 350,000 attendances for outpatient care each year, we have worked with our local partners to engage, and innovate pathways to support patients to access care in the most appropriate form as quickly as possible, reducing unnecessary face to face appointments. Our work has protected capacity for urgent care and elective service recovery, whilst ensuring access for the most vulnerable people through convenient digital alternatives. This work has included:
    - Virtual 1:1, group and multi-disciplinary case reviews in cardiac rehab, frailty, district nursing, physio, Speech and Language Therapy, diabetes, looked after children, Macmillan rehabilitation and more.
    - Support into care homes for frail elderly residents.
    - Remote care for children with diabetes
    - Remote care for women with gestational diabetes
    - Video consultations for oncology patients – keeping them safe
    - Delivering joint clinical interface sessions for primary and secondary care clinicians to discuss key conditions, pathways and provide advice.

Covid-19 Medicines Delivery Unit

- A multi-disciplinary team at CHFT, Locala and Local Care Direct (a social enterprise) have worked cohesively together to implement and deliver a new Covid-19 treatment service to the highest risk patients in our local community. These new treatments have resulted in patients avoiding hospital admissions and reducing the risk of these patients being severely unwell with Covid-19 infection. Doctors, pharmacists and support staff have worked closely with nursing colleagues in community services to provide a timely, efficient treatment service to patents in their own homes following the latest clinical guidelines. This service differs from other Covid Medicines Delivery Units (CMDUs) as it allows these vulnerable patients who are unwell to remain in their home to receive treatment rather than having to travel to the relevant treatment centre. Patient feedback on the service has been extremely positive, with patients being grateful to receive the treatment and not having to travel. This has led to an increased uptake of the service compared with other sites locally and nationally.

Climate Change

- We recognise our responsibility to reduce our impact on the environment. During 2021/22 we have developed a Green Plan that confirms the Trust is well aware that the key issues of climate change, air pollution and waste go far beyond the walls of our estate and are issues that impact everyone in the country. In recognition of this reality, the Trust is committed to a partnership working approach on sustainability with our peer organisations regionally and nationally. We will continue to engage with and support the sustainability agendas of our partner organisations. We are fully engaged in the climate/sustainability agenda, attending, and positively contributing to plans across West Yorkshire Health and Care Partnership and the West Yorkshire Combined Authority. The Trust has Director representation as a Commissioner on the Kirklees Climate Commission, who leads a sub-group on buildings. The Commission is an independent advisory body which brings people from the public, private and third sectors together to support and guide ambitious climate actions across all parts of Kirklees. The Commission supports Kirklees Council as it works towards net zero carbon emissions and greater climate resilience. The same Trust Director is also a member of Calderdale Council's Climate Action Plan working group which is focussing on the climate action plan content ahead of its adoption. Next steps include developing the thematic delivery plans over the next year regarding people and communities, buildings and technology, transport and land use and biodiversity.

Engagement with Patients and the Public

As we strive to deliver compassionate care we recognise that we need the involvement of our patients, carers, their relatives and the community to give them the best experience of care possible.

Engaging with patients is enshrined in the NHS Constitution and has become a key indicator of NHS performance nationally. We know that a positive experience during care leads to positive clinical outcomes. If a patient feels listened to and involved in their care they will respond better to medical, nursing and therapy interventions and also be better able to manage their own journey of care.

At CHFT we take every opportunity to hear from our patients, carers and their relatives, encouraging their active participation in shaping the way the Trust provides its services. This includes involving patients in decisions about their own care, seeking feedback about their experiences, and involving the public in planning future services, fundraising and volunteering. In this way we make sure our services are delivering the care that people want in the way that works best for them.

During 2021/2022 we had to work differently to carry out our engagement activities. We have continued to adapt and adjust to new ways of working under Covid restrictions with very positive engagement to enhance patient care. Some examples of patient engagement over the past year are given below.

Responding to feedback, the Trust has:

- Recruited and trained over 120 ward volunteers to help combat feelings of loneliness and isolation for patients and provided training opportunities for local residents.
- Implemented a robust process for capturing, sharing, and learning through patient stories, which are now a standard agenda item within our Patient Experience and Caring Group
- Developed a Carers Strategy with service users and local voluntary sector organisations that raises the profile of carers, improves education and training and supports person centred care
- Used patient and staff feedback to develop a 'sleep well at night' training video that has been rolled out to 80% of our clinical staff to date.
- Used a partnership approach to deliver a more patient centred way of supporting 'High Intensity Users' within our Emergency Departments - see below for further information
- Improved the pathway for cancer patients accessing treatment
- Set up a dedicated oncology patient helpline
- Developed a patient-led Visual Impairment Group

High Intensity User Initiative within our Emergency Departments (ED)

A group was set up to look at ways in which we could improve the patient experience for High Intensity Users (HIUs) attending our Emergency Departments five or more times per month.

Seventy percent of people who regularly access EDs live in deprived areas and the highest percentage fall in the 21- to 30-year-old age group.

Our aim, as a High Intensity User (HIU) Service, was to provide person-centred care using a case management approach to identify service-users care needs and match them to the most appropriate services. Staffing for the service includes two full time band 7 nurses one with a background in community services and the other with Emergency Department experience. Working collaboratively, they are able to highlight and address the needs of our HIUs

One of the key challenges with HIUs was engagement. We promoted engagement within our service by ensuring that our service is flexible, and supports a multi-agency approach, in line with the principles of trauma informed practice. Through our community engagement we have broken down barriers to engagement. For example, the new clinic brings health provision to service users rather than setting appointment times and discharging patients if they do not attend.

A further challenge faced was around raising awareness throughout the Trust and beyond about the role of the HIU service, fit with existing services and the criteria for accessing our service. We have delivered training to the last two intakes of new staff in ED, raising their awareness about the HIU service, how to make direct referrals and opening lines of communication for them to ask questions and seek advice if needed

Interventions from our service are enabling service users to live more independent, self-sufficient lives without reliance on primary and secondary care services. We are also breaking down previous barriers to engagement, allowing for health promotion. This is illustrated through the reduction of visits to ED following involvement from the HIU Group. Using the HIU dashboard we analysed the impact of 49 HIUs between February 2021 and December 2021. A six-month snapshot of each patient was analysed, comparing the first three months leading up to discussion at HIU against the following three months following interventions. This showed a reduction from 398 visits to ED to 88 visits.

The service has grown, and it has been showcased to the local Safeguarding Adults Board which involved safeguarding teams from both CHFT and the local Clinical Commissioning Group. We have contributed to commissioning groups, where we are able to guide policy, an example of this is our work within the Making Every Adult Matter (MEAM) group focusing on the roll out of a trauma informed approach across services. We showcased our service to the Trust Board to raise awareness of the impact of our service. We also contribute to a national community of HIU groups to share best practice.

The Trust continue to work with over 20 stakeholder groups, including third sector organisations to deliver our HIU initiative.

From a patient experience and engagement perspective we recognise we still have more to do. For 2022/2023 we are committed to embedding the learning we capture from our patients, carers and their relatives and strengthen our engagement activities across the health economy, especially for patients that are seldom heard and harder to reach.

Our engagement strategy will be agreed and monitored through our Patient Experience and Caring Group and regular updates will be provided within the patient experience section of our divisional Patient Safety Quality Boards.

Colleague Engagement

Details of engagement with colleagues across the Trust during the year is given within the staff report section of the Accountability Report.

Council of Governors (CoG)

The Council of Governors

The Council of Governors advises the Trust on how best to meet the needs of patients and the wider community we serve. The Council of Governors has a number of statutory duties, including holding the Non-Executive Directors to account for the performance of the Board of Directors and representing the interests of Trust members and members of the public.

The Council of Governors works with the Board of Directors to shape the Trust's future strategy and is responsible for providing feedback from members and stakeholders on proposed strategic developments.

The Trust keeps the Council of Governors fully informed on all aspects of the Trust's performance through formal council meetings. Comprised of elected and appointed Governors, as detailed below, the Council of Governors has decision-making powers defined by statute. These powers are outlined in the Trust's Constitution and principally refer to the appointment, removal and remuneration of the Trust Chair and Non-Executive Directors; the appointment and removal of the Trust's external auditors; the approval of the appointment of the Chief Executive; and receiving the Trust's annual accounts, any report of the auditor on the accounts and the Annual Report.

While the Council of Governors is responsible for holding the Board, and in particular, the Non-Executive Directors, to account and ensuring that it is acting in a way that means that the Trust will meet its obligations, it continues to remain the responsibility of the Board of Directors to oversee the running of the Trust.

The Council of Governors met formally eight times during 2021/2022, including the Annual General Meeting.

The Council of Governors meetings were held remotely via digital technology and were not open to members of the public. The agenda and minutes have continued to be made available and published on the Trust website.

The number of meetings attended by individual governors is recorded, and attendance for 2021/2022 is shown below based on how many meetings each governor was eligible to attend during their tenure:

Register of Council of Governors 2021-2022

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	DATE OF LEAVING/ ELECTION DUE	MEETINGS ATTENDED
PUBLIC – ELECTED					
1 – Calder and Ryburn Valleys	Jude Goddard	19.7.18	3 years	2021	0/3
1 – Calder and Ryburn Valleys	Peter Bamber	28.07.21	3 years	2024	4/5
1 – Calder and Ryburn Valleys	Gina Choy	28.07.21	3 years	2024	5/5
2 – Huddersfield Central	Sheila Taylor	19.7.18	3 years	2021	3/3
2 – Huddersfield Central	Christine Mills	19.07.18 28.07.21	3 years 3 years	2021 2024	8/8
2 – Huddersfield Central	Robert Markless	28.07.21	3 years	2024	3/5
3 – South Huddersfield	Chris Owen	17.7.19	3 years	2021	0/3
3 – South Huddersfield	Isaac Dziya	28.07.21	3 years	2024	2/5
3 – South Huddersfield	VACANT SEAT				
4 – North Kirklees	Veronica Woollin	15.9.16 17.7.19	3 years 3 years	2019 2022	5/8
4 – North Kirklees	VACANT SEAT				
5 – Skircoat and Lower Calder Valley	Stephen Baines	15.9.16 17.7.19	3 years 3 years	2019 2022	8/8
5 – Skircoat and Lower Calder Valley	Brian Richardson	18.9.14 15.9.17 15.9.20	3 years 3 years 1 year	2017 2020 2021	0/3
5 – Skircoat and Lower Calder Valley	Nicola Whitworth	28.07.21	3 years	2024	1/5
6 – East Halifax and Bradford	Annette Bell	17.9.15 19.7.18	3 years 3 years	2018 2021	2/3
6 – East Halifax and Bradford	Peter Bell	28.07.21	3 years	2024	0/5
6 – East Halifax and Bradford	VACANT SEAT				
7 – North and Central Halifax	Lynn Moore	18.9.14 18.9.17 18.9.20	3 years 3 years 1 year	2017 2020 2021	2/3
7 – North and Central Halifax	Alison Schofield	15.9.17 15.9.20 28.07.21	3 years 1 year 2 years	2020 2021 2023	5/8

7 – North and Central Halifax	Chris Matejak	28.07.21	3 years	2024	0/5
8 - Lindley and the Valleys	John Gledhill	17.7.19	3 years	2022	5/8
8 - Lindley and the Valleys	Brian Moore	28.07.21	3 years	2024	5/5
STAFF – ELECTED					
9 – Doctors/Dentists	Sandeep Goyal	28.07.21	3 years	2024	0/5
10 – Allied Healthcare Professionals/HCS/ Pharmacists	Sally Robertshaw	17.7.19	3 years	2022	4/8
11 – Management/ Admin/Clerical	Linzi Jane Smith	15.9.17 15.9.20	3 years 1 year	2020 2021	3/3
11 – Management/ Admin/Clerical	Emma Kovaleski	28.07.21	3 years	2024	3/5
12 – Ancillary	Jo Kitchen	28.07.21	3 years	2024	0/5
13 – Nurses/Midwives	Liam Stout	28.07.21	3 years	2024	3/5
13 – Nurses/Midwives	Jason Sykes	28.07.21	3 years	2024	1/5
APPOINTED					
University of Huddersfield	Prof Joanne Garside	01.01.21	3 years	2024	6/8
Calderdale Metropolitan Council	Cllr Megan Swift	3.10.17 Extended 1 year Extended 2 years	3 years 1 year 2 years	2020 2021 2023	3/8
Calderdale and Huddersfield Solutions Ltd (CHS)	Robert Dadzie	01.03.21 (Resigned mid-term)	3 years	2021	2/6
Calderdale and Huddersfield Solutions Ltd (CHS)	Abdirahman Duaale	31.03.22	3 years	2024	N/A
Kirklees Metropolitan Council	Cllr Lesley Warner	14.6.19	3 years	2022	5/8
Healthwatch	Helen Hunter	02.10.17 01.10.20 (Resigned mid-term)	3 years 3 years	2020 2023	2/6
Healthwatch	Karen Huntley	20.12.21	3 years	2024	1/2
Locala	Chris Reeve	21.11.17 21.11.20	3 years 3 years	2020 2023	0/8
South West Yorkshire Partnership NHS FT	Salma Yasmeen	18.10.17 18.10.20	3 years 3 years	2020 2023	4/8

As at 31 March 2022 there were 26 seats on the Council of Governors: 13 seats for publicly elected governors, 6 for elected staff governors and 7 for appointed governors from partner organisations.

Lead Governor

In line with the Foundation Trust Code of Governance, the Council of Governors elected Stephen Baines, one of its governors to be 'Lead Governor'. Elections of a lead governor take place on an annual basis. The Lead Governor acts as the main point of contact for NHS England / NHS Improvement (NHSE/I) should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate.

As a result of the Covid-19 pandemic, the lead governor appointment was extended for a further year to 2022, in consultation with governors.

Elections held within the reporting period

Governor elections were held during the financial year. Ten public seats and five staff seats were available and new governors were elected to seven of the public seats and all five of the staff seats. This left three public governor vacancies, in South Huddersfield, North Kirklees and East Halifax and Bradford.

During 2021/22 the Trust's appointed governor representing Calderdale and Huddersfield Solutions Limited resigned from the Trust and therefore Council of Governors and was replaced in March 2022. Helen Hunter, the appointed governor from Healthwatch, was replaced on the Council of Governors by Karen Huntley in-year.

Strengthening links between the Board and Governors and members

The Board of Directors is committed to working collaboratively with the Council of Governors. Executive and Non-Executive Directors value the role and contribution of governors and work openly and transparently with the Council.

There are four Council of Governor meetings per year, plus the Annual General Meeting. Board Directors are invited to attend the meetings and report on standing agenda items such as business planning, annual plans, service developments, quality and the Trust's financial position. Non-Executive Directors attend, giving governors the opportunity to hold them to account for the performance of the Board.

The Council of Governors receives the Integrated Performance Report at each of its meetings presented by the Chief Operating Officer and the Director of Finance.

The Chair of the Board of Directors also chairs the Council of Governors, providing a link between the two.

To strengthen the relationship further, a group of governors is invited to attend each Board of Directors meeting held in public. Governors are invited to meet with the Chair privately before each public Council of Governors meeting.

Governors sit on and observe each of the Board Committees: Finance and Performance; Audit and Risk; Charitable Funds; Quality; Workforce; Transformation Programme Board and the Nominations and Remuneration Committee of the Council of

Governors. Governors also have representation on other Trust committees/groups such as the Mortality Surveillance Group and the Organ Donation Committee.

Divisional Reference Group (DRG) meetings between governors and senior divisional staff take place three times a year. They are chaired by a publicly elected governor. These meetings give governors the opportunity to ask questions of senior clinical and managerial Trust colleagues, and challenge decisions as necessary. Divisional plans and performance are discussed, along with compliments and complaints and staffing and clinical issues.

DRG meetings took place in June 2021, November 2021 and February 2022.

Details of how members can contact the Council of Governors are shown on the Membership and Council of Governors pages on the Trust's external website. A dedicated e-mail address is provided for this purpose.

Governor training and development

To enable governors to discharge their duties, the Trust offers a variety of training and development sessions. Governors are required to attend a two-day induction course and Holding to Account training is mandatory on appointment and then again at two-year intervals.

Optional training sessions are also provided to help our governors feel more confident in their duty to hold Non-Executive Directors to account for the performance of the Board. These include sessions on NHS Finance, Understanding the Integrated Performance Report and Understanding Quality and Patient Experience.

The Trust also has a programme of governor workshop sessions. These are held throughout the year and are attended by governors, the Trust Chair and Board Directors.

The Trust Chair meets regularly with the lead governor of the Council of Governors for an exchange of views and an update on current topics. In addition, each newly elected or appointed governor is offered the opportunity to meet with the Trust chair on a one-to-one basis. These meetings help to set expectations and clarify the role of the Council of Governors/the governors and the support available to them.

Governors meet with the full Board of Directors at a workshop, this is usually twice a year but was held once during the year due to operational pressures. These workshops enable all parties to both look back and review progress on key developments and to look forward and jointly plan future strategic initiatives.

Governors also meet separately at least twice a year 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.

Governors are usually asked to consider and comment upon proposals for the Trust's forward plan and discuss this with the Board of Directors. Due to the Covid-19 pandemic there were changes to the financial regime and the 2021/22 priorities and operational planning guidance was issued late in the financial year, on 25 March 2021, with Trust plans not being required to be submitted until June 2021. The Director of

Finance briefed the Council of Governors on this position at their meeting in January 2022 and updated the Council of Governors on this via a formal meeting in April 2022.

Governor self-effectiveness questionnaire

As part of the Council of Governors cycle of business, it undertakes a review of its own effectiveness to ensure that it continues to fulfil its role and discharge its responsibilities in an appropriate way and to strive for continuous improvement in the way it operates.

The annual governors' effectiveness questionnaire was deferred in 2021 due to operational pressures and changeover of governors following the 2021 elections. The self-effectiveness questionnaire is scheduled to take place this year and on completion of this an action plan will be developed.

Governor involvement at the Trust

In 2021/22 direct governor involvement has continued to be affected due to the Covid-19 pandemic. However, governors have continued to attend meetings virtually. Through the use of MS Teams, in January 2021 governors were able to resume sitting on "user panels" as part of the interview process for senior level posts in the organisation.

Governors have also been involved in reviewing patient literature throughout the year.

A number of governors have been involved with a new quality improvement initiative at the Trust, called Observe and Act, which forms part of our ward assurance process known as "Journey to Outstanding". This is a tool developed by another Trust to look at "a person's total experience of a service from the service user/carer perspective, learn from it, share good practice and where necessary act to make improvements". We have piloted the digital use of the Observe and Act patient experience tool, with a number of governors trained in how to use the toolkit and involved in a number of virtual visits to wards together with colleagues and Non-Executive Directors since the project's launch.

Expenses claimed by governors during 2021/22

Governors do not receive payment for their work with the Trust. However, any travel expenses incurred while on Trust business are reimbursed at a rate of 0.28p per mile. Currently the Trust also reimburses the cost of a carer at meetings for one of the public governors who requires carer support.

During 2021/22 the following expenses were claimed, compared with 2020/21:

	2020/21	2021/22
Number of Governors	24	26
Number claiming expenses	1	1
Total expenses claimed	**£352.85**	**£421.76**

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 Foundation Trust and members of the Council of Governors or parties related to them.

There were no such transactions for the period 1 April 2021 to 31 March 2022.

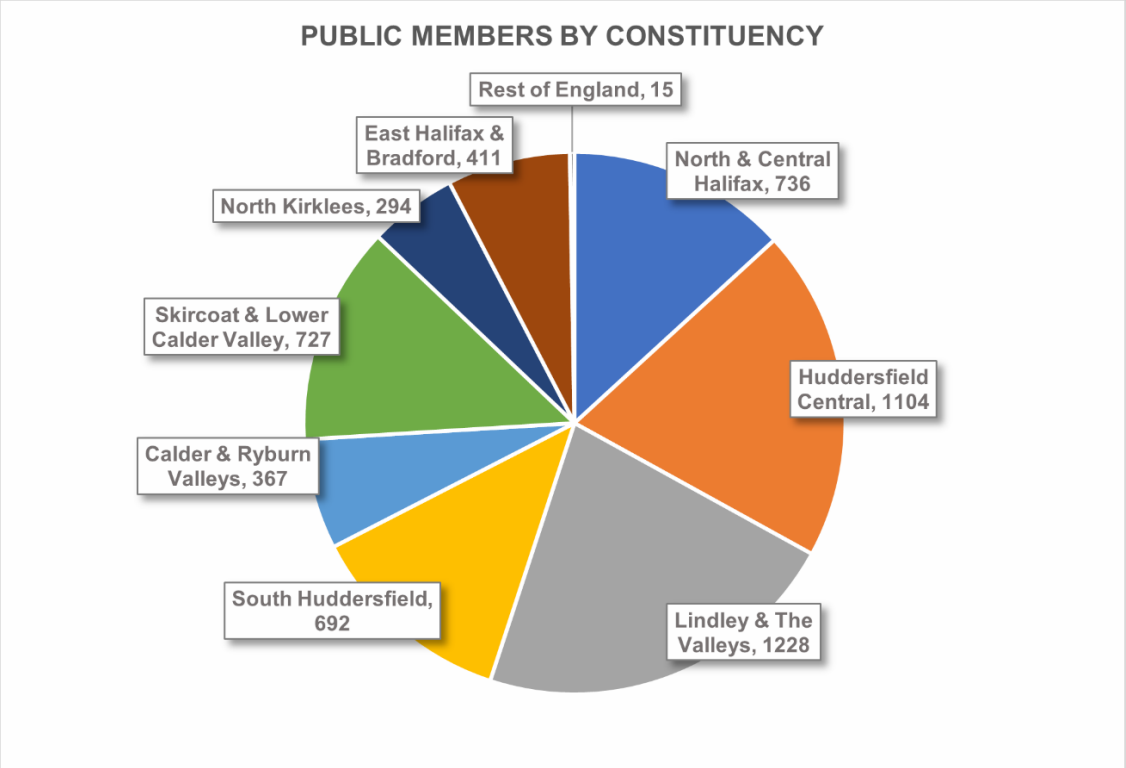
Our Membership

As an NHS Foundation Trust, we are required to have a membership community. A fundamental part of being an NHS Foundation Trust is the way the organisation is structured, based upon the involvement of local people, patients, carers, partner organisations and staff employed by the Trust.

Members share their views and influence the way in which the Trust runs and develops its services. The Trust considers its membership to be a valuable asset, which helps guide its work and the decisions it makes, while also holding the organisation to account and ensuring we adhere to NHS values.

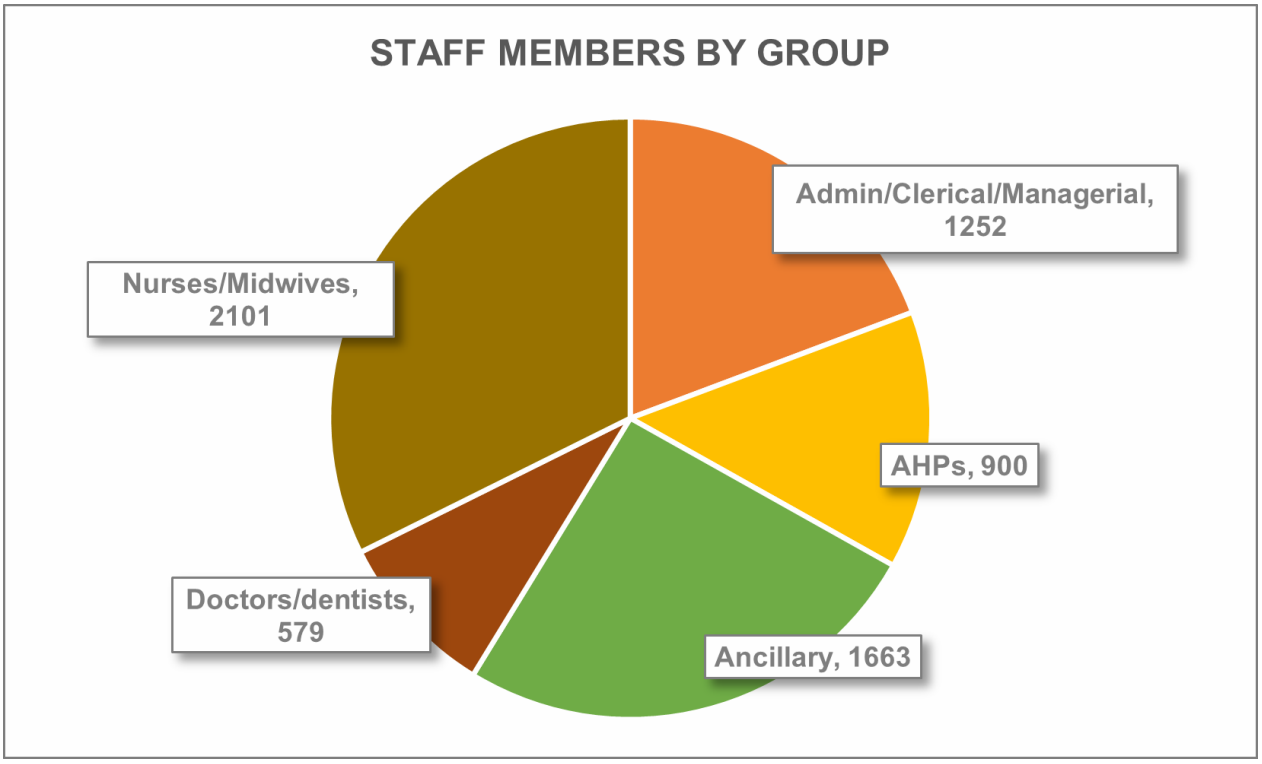
The Trust has two membership categories: public members, who are over 16 years of age and staff members who are employees contracted to work for the Trust for at least one year.

The number of public members as at 31 March 2022 is 5574, broken down by constituency as follows:



We encourage membership applications from all sectors of our communities, to develop a wide and diverse membership, and we try to provide different ways for the people we serve to contribute to the success of our organisation.

The number of staff members as at 31 March 2022 is 6495, broken down by staff group as follows:



Membership and Engagement Strategy

The Trust has a Membership and Engagement Strategy covering the three-year period 2020-2023.

The strategy outlines what we will do over the three-year period to achieve our vision for membership and engagement, which is that we will be directly accountable to local people by making the best use of our membership communities. It describes the methods we intend to use to create and maintain a representative membership and strengthen engagement and communication with members over the period.

The strategy has three overarching goals:

- Our membership community will be active and engaged; be representative of our local communities and increase year on year;
- Our governors will have regular, meaningful, two-way engagement with our membership community and members of the public;
- Our membership community will have a voice and opportunities to get involved and contribute to the organisation, our services and our plans for the future.

The Trust has a large public membership which is analysed on a regular basis against census data to assess whether it is representative of the diverse communities that it serves.

The analysis (see below) shows that we have under representation in three sectors of our communities, namely younger people, males and those with an ethnic group of Asian/Asian British:

Our Members	% of members	% of eligible members
Gender		
Female	64.5%	48.6%
Male	35.5%	51.4%
Transgender	0.02%	Not available
Ethnicity		
White	85.5%	83.6%
Mixed	2.1%	1.5%
Asian or Asian British	9.2%	12.6%
Black or Black British	2.8%	1.6%
Other	0.5%	0.6%
Age band (years)		
16-24	1.6%	15.1%
25-34	14.9%	16.0%
35-44	8.1%	16.0%
45-54	14.3%	17.5%
55-64	17.4%	14.4%
65-74	19.9%	11.8%
75-84	16.8%	6.6%
85+	7.0%	2.5%

The under-represented groups have been given special focus during recruitment and engagement activities in 2021/22, although activities have continued to be hampered by the COVID-19 pandemic and have been virtual for the most part, via leaflets and flyers.

Actions we have taken to meet the goals from our Membership and Engagement Strategy during 2021/22 include:

- Establishing a Membership and Engagement Working Group (MEWG), which will coordinate and oversee the collective work of the Membership Office and the Council of Governors so that the two can co-create on member recruitment and engagement activities.

  This will help governors to meet their obligations to seek the views of members and the public on material issues or changes being discussed by the trust and feed back to members and the public information about the trust, its vision, performance and material strategic proposals made by the trust board.

  The MEWG will support the development and implementation of the Trust's Membership and Engagement Strategy.

The MEWG, which consists of public and staff governors, public members, a comms representative, a Colleague Engagement Advisor and Membership and Engagement representatives, had its first meeting in March 2022.

- Undertaking an electronic survey of our members to establish how they would like us to engage with them and how often, together with the topics/issues they would like to hear about.

  We received a good response to the survey and have developed plans based on the feedback. These include the introduction of an e-mail three times a year from our governors to members with updates on service changes and improvements, a review of our member engagement events and the introduction of the MEWG as described above.

  The survey will take place annually from here on in.

- Commissioning engagement training for public and staff governors from NHS Providers, to equip our governors with the skills they will need to undertake engagement activities once these are possible again after the COVID-19 pandemic.

- Agreeing with our local Healthwatch that our governors will be involved with their public engagement activities once they are running again.

- Introducing a click-through banner on the front page of the CHFT website promoting membership and signposting visitors to the relevant pages on the Trust's website.

- Making more use of social media to attract more members and to engage with our existing members and members of the public.

Register of Council of Governors' interests

All Governors have a responsibility to declare relevant interests as defined in our Constitution. These declarations are made to the Company Secretary and are reported to the Council and entered into a register.

The public can access the register at www.cht.nhs.uk or by making a request in writing to:

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

The Chair of the Board is also required to disclose any other significant commitments to the Council of Governors. The Chair did not have any other significant commitments to disclose during 2021/22**.**

Membership of Committees

The Council of Governors has established a Nominations and Remuneration Committee to consider the pay and succession arrangements for the Non-Executive Directors.

Nominations and Remuneration Committee of the Council of Governors (Non-Executive Directors

The Nominations and Remuneration Committee (Council of Governors) met six times during 2021/22 and the following items were discussed at the meetings:

- Reviewed and agreed the Chair's and Non-Executive Directors appraisal process
- Reviewed and agreed Non-Executive Director Succession Plan
- Received the outcome of the Chair's appraisal
- Agreed to pilot two Associate Non-Executive Director post, one for the Trust and one for CHS
- Approved the appointment for two Associate Non-Executive Directors
- Reviewed the Terms of Reference
- Agreed the recruitment process for three Non-Executive Directors, including the Chair
- Supported a Constitution change relating to the geographical eligibility criteria
- Approved the shortlisting and the appointment of the new Trust Chair

The Nominations and Remuneration Committee (Council of Governors) during 2021/2022 comprised a majority of Governors. The membership for the Committee was as follows:

Philip Lewer, Chair
Richard Hopkin, Senior Independent Non-Executive Director
Stephen Baines, Public Governor / Lead Governor
Veronica Woollin, Public Governor
Alison Schofield, Public Governor (until 31.10.21)
Christine Mills, Public Governor (until 31.10.21)
Lynn Moore, Public Governor (until 28.07.21)

From 1 November 2021 the following members joined the Committee:

Peter Bamber, Public Governor
Isaac Dziya, Public Governor
Brian Moore, Public Governor
Nicola Whitworth, Public Governor

Attendance at the Nominations and Remuneration Committee (Council of Governors) meetings were as follows:

NAME	Role	19.04.21	01.07.21	09.08.21	02.11.21	09.12.21	02.03.22
Philip Lewer	Chair	✓	×	✓	✓	✓	×
Richard Hopkin	Senior Independent Non-Executive Director	✓	✓	×		✓	✓
Stephen Baines Lead Governor	Publicly Elected Governor	✓	✓	✓	✓	✓	✓
Veronica Woollin	Publicly Elected Governor	✓	×	×	✓	✓	×
Alison Schofield	Publicly Elected Governor	×	✓	✓			
Christine Mills	Publicly Elected Governor	✓	✓	✓			
Lynn Moore	Publicly Elected Governor	✓	✓				
Isaac Dziya	Publicly Elected Governor				✓	✓	×
Peter Bamber	Publicly Elected Governor				✓	×	✓
Nicola Whitworth	Publicly Elected Governor				✓	✓	✓
Brian Moore	Publicly Elected Governor				✓	✓	✓

How to get in touch

If you would like to get in touch with a governor, or would like to find out more about becoming a member of 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, Acre House, Acre Street, Lindley, Huddersfield HD3 3EA.

Alternatively, visit our website at www.cht.nhs.uk.

Remuneration Report

I am pleased to present the Remuneration Report for 2021/2022. 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 Nominations and Remuneration Committee (Board of Directors) is established for overseeing the recruitment and selection process for Executive Directors and for 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 Workforce and Organisational Development

The Committee also considers other Director-level posts that are non-voting members of the Board.

Details of the membership of the Nominations and Remuneration Committee (Board of Directors) and individual attendance can be found below.

Annual statement on remuneration
The Nominations and Remuneration Committee (Board of Directors), in setting the pay of the Executive Directors, based its decisions on pay guidance from NHS England/NHS Improvement (NHSE/I) and available benchmarking data.

The membership of the Committee during 2021/2022 was as follows:

Philip Lewer – Chair
Alastair Graham – Non-Executive Director
Karen Heaton – Non-Executive Director
Denise Sterling – Non-Executive Director
Peter Wilkinson – Non-Executive Director
Richard Hopkin – Non-Executive Director
Andy Nelson – Non-Executive Director, for nomination items only

Professional advice to the Committee was provided by the Director of Workforce and Organisational Development at the meeting on 17 August 2021, 11 February 2022 and the Deputy Director of Workforce and Organisational Development at the meeting on 12 January 2022.

During 2021/2022, four meetings were held and the following items were discussed:

- Chief Executive recruitment process
- Review of terms of reference
- Director pay award position
- Calderdale and Huddersfield Solutions Ltd Terms and Conditions
- Recruitment of Director posts
- Board succession plan

The Trust remuneration report is subject to a full external audit and details of remuneration and pension information are detailed on pages 98 - 104.

Remuneration Policy

The Trust's remuneration policy applies to Non-Executive Directors, Executive Directors and non-Board Directors and is based upon open, transparent and proportionate pay decisions. All pay decisions are based on pay advice and guidance issued by NHS England/NHS Improvement (NHS E/I) and the use of market intelligence from the NHS and where appropriate non-NHS sectors. Our remuneration approach is 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 pay guidance received from the sector regulator, NHS E/I and the Department of Health and Social Care. The Committees, when required, also access professional independent reports which capture objective evidence of pay benchmarking across a range of NHS and non-NHS comparators. The way in which the Committees operate is subject to audit scrutiny. The Committees are subject to an independent level of scrutiny by the Audit and Risk Committee and this scrutiny can be exercised at any time. This scrutiny role is set out in the Terms of Reference for the Audit and Risk Committee. The Audit and Risk Committee Chair does not sit on the Nominations and Remuneration Committee when remuneration is being considered. The Trust will continue with this approach to the remuneration of Directors in future years.

The Trust has well established performance management arrangements and each year I undertake an appraisal for each of the Executives and Non-Board Directors. I am appraised by the Chair. The Trust does not have a system of performance-related or bonus 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.

Executive Directors and non-Board Directors are employed on permanent contracts with a six month notice period. Where a contract is terminated without the postholder receiving full notice, compensation would be limited to the payment of the salary for the contractual notice period. There is 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 compensation for early termination. The Trust has no additional service contract obligations.

Salary and pension contributions of all Executive and Non-Executive Directors
Information on the salary and pensions contributions of all executive and Non-Executive Directors is provided in the tables on the following pages. The information in these tables has been subject to audit by our external auditors KPMG LLP.

Professor Brendan Brown
Chief Executive

5 July 2022

Salary, Expenses and Pension entitlements of senior managers

A. Remuneration

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

Name and Title	2021-22					
	Salary	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonus	*Pension Related Benefits	Total
	(bands of £5,000) £000	£	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
P Lewer ~ Chair	50 - 55	0	0	0	0	50 - 55
R Hopkin ~ Deputy Chair and Chair of Finance & Performance Committee, Senior Independent Non-Executive Director (NED)	15 - 20	0	0	0	0	15 -20
K Heaton ~ NED (Chair of Workforce Committee)	10 -15	0	0	0	0	10 -15
A Nelson ~ NED (Chair of Audit and Risk Committee)	15 - 20	0	0	0	0	15 - 20
A Graham ~ NED (Chair of Calderdale and Huddersfield Solutions Ltd)	10 -15	0	0	0	0	10 -15
P Wilkinson ~ NED (Chair of Transformation Programme Board)	10 -15	0	0	0	0	10 -15
D Sterling ~ NED (Chair of Quality Committee)	10 -15	0	0	0	0	10 -15
N Seanor ~ Associate NED (Note A)	0 - 5	0	0	0	0	0 - 5
G Boothby ~ Director of Finance	135 -140	0	0	0	37.5 - 40	175-180
S Dunkley ~ Director of Workforce and Organisational Development	125-130	0	0	0	27.5 -30	155-160
D Birkenhead ~ Medical Director (Note B)	230-235	0	0	0	70 -72.5	300-305

E Armistead – Deputy Chief Executive/Director of Nursing & Interim Chief Executive (Note C)	160-165	0	0	0	72.5- 75	230-235
H Barker ~ Chief Operating Officer (Note D)	80-85	0	0	0	5 -7.5	85 -90
O Williams ~ Chief Executive (Note E)	125 -130	0	0	0	0 - 2.5	125 -130
B Brown ~ Chief Executive (Note F)	50-55	0	0	0	10 -12.5	60 - 65
J Fawcus ~ Chief Operating Officer (Note G)	50-55	8	0	0	0 - 2.5	55-60
B Walker ~ Interim Chief Operating Officer (Note H)	20-25	0	0	0	0 - 2.5	20-25
K Archer ~ Interim Director of Finance (Note I)	20-25	0	0	0	10 -12.5	35-40
L Rudge ~ Interim Director of Nursing (Note J)	20-25	0	0	0	15-17.5	35-40
Additional disclosure						
Band of the highest paid Director's total remuneration	230 - 235	-	-	-	-	-
Median Total (£'000)	29875	-	-	-	-	-
Remuneration ratio	7.78	-	-	-	-	-

Name and Title	2020-21					
	Salary	Taxable Benefits	Annual Performance Related Bonuses	Long Term Performance Related Bonus	*Pension Related Benefits	Total
	(bands of £5,000) £000	£	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
P Lewer ~ Chair	50 - 55	0	0	0	0	50 - 55
R Hopkin ~ Deputy Chair and Chair of Finance & Performance Committee, Senior Independent Non-Executive Director	10 -15	0	0	0	0	10 -15
K Heaton ~ NED (Chair of Workforce Committee)	10 -15	0	0	0	0	10 -15
A Nelson ~ NED (Chair of Audit and Risk Committee)	15 - 20	0	0	0	0	15 - 20
A Graham ~ NED (Chair of Calderdale and Huddersfield Solutions Ltd)	10 -15	0	0	0	0	10 -15
P Wilkinson ~ NED (Chair of Transformation Board)	10 -15	0	0	0	0	10 -15
D Sterling ~ NED (chair of Quality Committee)	10 -15	0	0	0	0	10 -15
G Boothby ~ Director of Finance	135 -140	0	0	0	20 - 22.5	155-160
S Dunkley ~ Director of Workforce and Organisational Development	125-130	0	0	0	27.5 -30	155-160
D Birkenhead ~ Medical Director (Note B)	230-235	0	0	0	0 - 2.5	230-235
E Armistead – Deputy Chief Executive/Director of Nursing	150-155	0	0	0	107.5 -110	260 -265
H Barker ~ Chief Operating Officer	135-140	0	0	0	30 -32.5	165-170
O Williams ~ Chief Executive	190-195	0	0	0	5 -7.5	195-200
Additional disclosure						
Band of the highest paid Director's total remuneration	230 - 235					
Median Total (£'000)*	26970					
Remuneration ratio	8.62					

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

Note A, N Seanor commenced as Associate Non-Executive Director from 15 December 2021.
Note B, D Birkenhead re-joined the NHS Pension from 1 April 2022. No pension related benefits were reported in 2020/2021 as not in the NHS Pension for the full year.
Note C, E Armistead appointed Interim Chief Executive from 8 November 2021 to 31 December 2021.
Note D, H Barker left the Trust on 31 October 2021.
Note E, O Williams left the Trust on 5 November 2021.
Note F, B Brown commenced as Chief Executive on 1 January 2022.
Note G, J Fawcus commenced as Chief Operating Officer on 7 November 2021.
Note H, B Walker appointed as Interim Chief Operating Officer from 1 October 2021 to 30 November 2021.
Note I, K Archer appointed as Interim Director of Finance from 26 August 2021 to 1 November 2021.
Note J, L Rudge appointed as Interim Director of Nursing from 8 November 2021 to 31 December 2021.

*The median ratio for 2020/21 has been restated from £27,352 and a ratio of 8.50 to £26,970 and a ratio of 8.62

***Pension Related Benefits**

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual.

The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.
This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual.

Additional disclosure

The salary for the Medical Director is their total remuneration package, in 2021/22 and 2020/21 the Medical Director had no direct clinical activity, for which payment was made.

NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in the organisation in the financial year 2021/2022 was £232,500 (2020/2021, £232,500).

This is a change between years of 0%, (2020/21 was 0%).

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2021/2022 was from £0 to £358,000 (2020/21 £0 to £324,000). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by full time equivalent number of employees) between years is 8.4% (2020/2021 it was minus 3.7%). 6 employees received remuneration in excess of the highest paid director in 2021/2022, (2020/2021 there were 2 employees).

The percentage change from 2020/21 is as a result of higher pay awards for Agenda for Change and medical employee groups and an increase in the number of full-time equivalent number of employees employed by the Trust.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below.

The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

2021/22	**25th Percentile**	**Median**	**75th percentile**
Salary component of pay £	£20,329	£29,873	£40,057
Total pay and benefits excluding pension benefits £	£20,329	£29,873	£40,057
Pay and benefits excluding pension: pay ratio for highest paid director	11.44:1	7.78:1	5.80:1

2020/21	**25th Percentile**	**Median**	**75th percentile**
Salary component of pay £	£19,549	£27,353	£37,890
Total pay and benefits excluding pension benefits £	£19,549	£27,353	£37,890
Pay and benefits excluding pension: pay ratio for highest paid director	11.8:1	8.50:1	6.14:1

There has been no change to the pay band for the highest paid director in 2021/2022. The marginal change to the ratio between the highest paid director is the result of higher pay awards for Agenda for Change and medical employee groups and an increase in the full-time equivalent number of employees employed by the Trust.

B) Total Pension Entitlement

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 2022 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2021	Real Increase /(Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2022	Employer's contribution to stakeholder pension
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
G Boothby ~ Director of Finance	2.5-5	0 - 2.5	60-65	75- 80	846	54	904	0
S Dunkley ~ Director of Workforce and Organisational Development	0-2.5	0 - 2.5	5-10	0 - 5	85	28	114	0
D Birkenhead ~ Medical Director	2.5 - 5	2.5 - 5	85 -90	215-220	1777	117	1,903	0
E Armistead – Director of Nursing and Deputy Chief Executive (Note B)	2.5-5	5 - 7.5	70-75	160 -165	1,374	111	1,492	0
H Barker ~ Chief Operating Officer (Note C)	0-2.5	0 - 2.5	65 - 70	150 -155	1,340	11	1,370	0
O Williams ~ Chief Executive	0-2.5	0 - 2.5	75-80	0 - 5	1,149	6	1,160	0
B Brown ~ Chief Executive (Note E)	0 - 2.5	0 - 2.5	20-25	0 - 5	204	5	254	0
J - Fawcus ~ Chief Operating Officer (Note F)	0 - 2.5	0 - 2.5	35-40	75- 80	603	22	681	0
B Walker ~ Acting Chief Operating Officer - (Note G)	0 - 2.5	2.5 - 5	40-45	130-135	1,340	0	0	0
K Archer ~Acting Director of Finance (Note H)	0 - 2.5	0 - 2.5	30-35	60 - 65	439	8	500	0
L Rudge ~ Interim Director of Nursing (Note I)	0 - 2.5	0 - 2.5	40-45	85 -90	655	14	772	0

Cash Equivalent Transfer Values

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

Real Increase/ (Decrease) in CETV

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

Staff Report

We employ 6,126 colleagues (6,581 including Calderdale and Huddersfield Solutions Limited) across our two hospitals and in the community in Calderdale.

Gender

Board of Directors	8 (56%) Male 	5 (44%) Female 
Other employees (CHFT)	18% 	82% 

Staff costs

Staff costs				
				Restated
			2021/22	2020/21
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	216,367	35,703	**252,070**	235,945
Social security costs	24,077	-	**24,077**	21,875
Apprenticeship levy	1,208	-	**1,208**	1,095
Employer's contributions to NHS pension scheme	40,779	-	**40,779**	38,338
Pension cost - other	130	-	**130**	106
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	-	-	**-**	-
Temporary staff	-	7,636	**7,636**	4,529
Total gross staff costs	**282,562**	**43,339**	**325,900**	**301,889**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**282,562**	**43,339**	**325,900**	**301,889**
Of which				
Costs capitalised as part of assets	348	-	**348**	409

The 2020/21 costs have been restated for both Group and Trust to correct classification of costs, Salaries and wages, Group was £239,922k now £235,945k, Trust was £230,751k now £226,775k, Social security costs, Group was £20,147k now £21,875k, Trust was £18,796k now £21,239k, Apprenticeship levy, Group was £1,007k now £1,095k, Trust was £979k now £1,067k and Employer's contributions to NHS pensions, Group was £36,176k now £38,338k, Trust was £35,275k now £37,437k.

Average number of employees (WTE basis)

	Permanent	Other	2021/22 Total	202021 Total
	Number	Number	Number	Number
Medical and dental	654	23	**677**	653
Ambulance staff	2	-	**2**	-
Administration and estates	1,015	65	**1,080**	1,026
Healthcare assistants and other support staff	1,669	158	**1,827**	1,702
Nursing, midwifery and health visiting staff	1,653	137	**1,790**	1,732
Nursing, midwifery and health visiting learners	-	-	**-**	-
Scientific, therapeutic and technical staff	750	19	**769**	747
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	-	-	**-**	-
Total average numbers	**5,743**	**402**	**6,145**	5,860
Of which:				
Number of employees (WTE) engaged on capital projects	19	-	**19**	12

Reporting of compensation schemes - exit packages 2021/22

The payment relates to accrued contractual notice.

	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	-	1	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**1**	**1**
Total cost (£)	£0	£4,583	**£4,583**

Reporting of compensation schemes - exit packages 2020/21

The payment represented a mutually agreed settlement based on contractual obligations.

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	1	**1**

£10,000 - £25,000		-	-		**-**
£25,001 - 50,000		-	-		**-**
£50,001 - £100,000		-	-		**-**
£100,001 - £150,000		-	-		**-**
£150,001 - £200,000		-	-		**-**
>£200,000		-	-		**-**
Total number of exit packages by type		**-**	**1**		**1**
Total resource cost (£)		£0	£1,000		**£1,000**

Exit packages: other (non-compulsory) departure payments

	2021/22		2020/21	
	Payments agreed	**Total value of agreements**	**Payments agreed**	**Total value of agreements**
	Number	**£000**	**Number**	**£000**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	5	-	-
Exit payments following Employment Tribunals or court orders	-	-	1	1
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**1**	**5**	**1**	**1**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

The information in these tables has been subject to audit.

Off payroll engagements -

Table 1: For all off-payroll engagements as of 31 March 2022, for more than *£245* per day and that last for longer than six months

Number of existing engagements as of 31 March 2022	0
Of which...	
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022, for more than *£245* per day and that last for longer than six months.

Number of new engagements, or those that reached six months in duration, between 1 April 2021 and 31 March 2022 of which:	0
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of Board members, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022

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

Consultancy Spend

During 2021/22 the Trust spent £228K on consultancy.

2021 Staff Survey

The NHS staff survey is conducted annually. From 2021/22 the annual NHS Staff Survey questions have been redesigned to align with the seven elements of the NHS "People Promise". This is a promise we must all make to each other – to work together to improve the experience of working in the NHS for everyone. The staff survey retains the two previous themes of engagement and morale. These replace the ten indicator themes used in previous years. All indicators are based on a score out of 10 for specific questions with the indicator score being the average of those. The Staff Survey is the principal way to measure progress on the People Promise and will enable teams and departments, as well as whole organisations, to see their progress and take action to improve.

Our response rate to the 2021/22 survey dropped slightly to 48% from 50% in 2020.

The scores for the 'Promise' elements and two themes are set out below:

Indicators ('People Promise' elements and themes)	**2021/22**	
	Trust Score	**Benchmarking**
People Promise:		
We are compassionate and inclusive	7.2	7.2

We are recognised and rewarded	5.7	5.9
We each have a voice that counts	6.7	6.7
We are safe and healthy	5.8	6.0
We are always learning	5.1	5.3
We work flexibly	5.8	6.0
We are a team	6.5	6.6
Staff engagement	6.7	6.8
Morale	5.6	5.8

2019/20 and 202/21
Scores for each indicator together with that of the survey benchmarking for acute Trusts in the previous two years are presented below:

	2020/21		2019/20	
	Trust	**Bench-marking Group**	**Trust**	**Bench-marking Group**
Equality, diversity and inclusion	9.2	9.1	9.1	9.0
Health and wellbeing	5.9	6.1	5.5	5.9
Immediate managers	6.7	6.8	6.7	6.8
Morale	6.1	6.2	6.0	6.1
Quality of care	7.4	7.5	7.4	7.5
Safe environment – bullying and harassment	8.1	8.1	8.0	7.9
Safe environment – violence	9.3	9.5	9.4	9.4
Safety culture	6.8	6.8	6.4	6.7
Staff engagement	6.9	7.0	6.9	7.0
Team working	6.3	6.5	6.4	6.6

Significant improvement between 2019/20 and 2020/21 was seen in the following areas:

Q11a. organisation takes positive action on health and wellbeing – increase of 28.1% from 32% to 60.1%

Q3c. Opportunities to show initiative frequently in my role – increase of 2.8% from 70.7% to 73.5%

Q9c. Immediate manager asks for my opinion before making decisions that affect my work – increase of 2.5% from 51% to 53.5%

Q17a. Would feel secure raising concerns about unsafe clinical practice – increase of 2.2% from 73.9% to 76.1%

Q3a. Always know what work responsibilities are – increase of 1.9% from 85.1% to 87%

Areas where our scores reduced by 6% or more were:

Q2a. Often/always look forward to going to work – decreased by 8.2% from 53.4% to 45.2%

Q2b. always/often enthusiastic about my job – decreased by 6.2% from 70.7% to 64.5%

Q3i. Enough staff at organisation to do my job properly – decreased by 10.2% from 33.3% to 23.1%

Q11d. In last 3 months, have not come to work when not feeling well enough to perform duties – decreased by 7.6% from 52.8% to 45.2%

Q21c. Would recommend organisation as place to work – decreased by 8.8% from 63.8% to 55%

Q21d. If friend/relative needed treatment would be happy with standard of care provided by organisation – decreased by 7.9% from 71.6% to 63.7%

We have identified five priorities for 2022/2023 which are aligned to the NHS People Plan:

1. Health and wellbeing (NHS People Plan – looking after our people/belonging)

    - Enhanced wellbeing support at local level. Psychologist working within the Workforce and Organisational Development (WOD) directorate to provide on-site support to understand the root cause of exhaustion, burn out, stress and frustration, providing interventions to support colleagues locally, health and

wellbeing at the centre of people conversations, wellbeing ambassador development, wellbeing hour evolution

2. Leadership visibility (NHS People Plan – belonging)

    - All leaders to be members of care club, 'back to the floor' volunteering to support the front line to understand colleagues' day to day roles, opportunities and challenges

3. Development opportunities for all (NHS People Plan – growing for the future)

    - Production of a development for all toolkit to support colleagues who wish to progress, grow in role or support the growth of others. Quality discussions will be held between line managers and colleagues that will focus on career planning. The manager/colleague will be supported with a wealth of resources and programmes that will underpin our talent approach.

4. Intensive care support for areas demonstrating the need for additional support (NHS People Plan - new ways of working/belonging)

    - Dedicated support for those teams that have highlighted a significant drop in results or a year and year decline in score over the past four years
    - Work Together/Get Results - Create tools and resources to co create improvements colleagues want to see. The framework will support change and enhance teamwork.

5. Equality, Diversity and Inclusion (EDI) – (NHS People Plan – belonging)

    - Executive Sponsors supporting EDI conversations at Board,
    - Enhanced communications regarding the impact of the equality groups
    - Cultural awareness toolkit
    - Inclusive leadership modules within the leadership development programmes including authentic conversations with members of the equality groups regarding the role leaders play in supporting people of difference.

The Trust has developed a robust action plan to address the areas of concern highlighted in the staff survey, but which also maintains focus on the areas of success, such as wellbeing. This will include an intensive programme of support for hotspot areas.

The Workforce Committee oversees performance in the staff survey, the Trust response to feedback and progress in improving our scores and the overall colleague experience.

Equality, Diversity and Inclusion (ED&I)

We continue to be highly committed to being instrumental in delivering a health service where equality, diversity and inclusion are embraced and communicated in our everyday lives. As an organisation, we recognise and celebrate the value the difference that diversity brings and how, through Inclusion, we can work together to get results. The Trust's 5-year inclusion strategy sets out how the organisation strives towards delivering change and our policy ensures that employment matters adhere to

best practice and legislation. Performance is monitored by the Workforce Committee. When considering performance outcomes, the Committee will seek to ensure the outcomes align with overall business performance. We have several organisation sponsored, colleague led, equality network groups for BAME, Disability, Pride, Women's Voice, Armed Forces, Carers and International colleagues. These groups help review and inform the Trust's action plans, policies and procedures. The terms of reference for these groups include the following provision:

- to promote a work environment in which colleagues feel supported and valued, whilst enabling them to fulfil their potential and contribute fully to the benefit of the service and our patients
- to challenge discrimination and to positively promote equality
- to manage a network that can offer advice and support to others
- to ensure that good practice and initiatives to promote issues are shared
- to provide a forum for discussion and debate which draws on knowledge and experience
- to act as a driving force to promote continuous practice improvement
- to develop and coordinate an action plan for positive change and ensure Trust policies are inclusive
- to assist the Trust in meeting its obligations regarding its duty under the Equality Act and NHS Equality Delivery System (EDS)
- to provide a place for colleagues to receive peer support i.e. raise concerns and ideas in a safe and confidential environment

LGBTQ+
In the last 12 months, we've worked hard to develop colleague network and have rebranded this as the Pride network. Over 2500 colleagues wear their NHS Rainbow Lanyard with pride and they have all pledged to take action to support inclusion and accessibility to services. We flew our Progress Pride flag outside Huddersfield Royal Infirmary in June 2021 and celebrated pride in the NHS week in September 2021. Our Pride network plays an important role in ensuring we value and celebrate diversity, sharing their experiences and highlighting important events.

Disability
We are committed to the employment and career development of people with disabilities, we are a Disability Confident employer. We have a Colleague Disability Action Group in place and we are working on our Workforce Disability Equality Plan. Our disabled colleagues contribute to proposals around service and policy changes through our Equality Impact Assessments.

Project Search
Through Project Search, the Trust offers young adults with learning difficulties, disabilities or autism, opportunities to support them on their employability journey through a blend of work experience and classroom learning. This is a tripartite agreement with the local council, local college and the Trust. During the pandemic the work experience was required to pause due to safety purposes, however, the learning and the networking between the three parties has since continued with young people now back in placements and having a huge impact on our patient experience. We continue to recognise that positive action can help remove barriers to employment and pro-actively address the under-representation of disabled staff in employment.

Ethnicity
We have an established network group of colleagues with over 100 members who sustained their meetings during the pandemic to meet quarterly via Microsoft teams. The group is involved in the design of Equality Impact Assessments related to service and policy redesign as well as contributing as a stakeholder group in our service reconfiguration plans. We continue to submit our Workforce Race Equality Standard (WRES) data and work together on our plans. There remains significant work to do with education and awareness a vital element of our plan. Covid-19 has seen particular challenges for our colleagues with black, Asian and minority ethnic heritage. We celebrated Windrush Day with flying the Windrush flag outside HRI and we supported the 'Root Out Racism' campaign. More information on the 'Root Out Racism' campaign is available via the link below. https://www.wypartnership.co.uk/get-involved/root-out-racism

Equality and Diversity is a Trust essential safety training requirement for all colleagues. Compliance with this training was 94.15% for 2021/22.

Gender
We host an annual International Women's Day event and established a 'Women's Voices' network in 2021. The Trust's gender pay gap position has reduced in the last 12 months but remains strongly influenced by the pay and gender make-up of the medical and dental staff group (i.e. Doctors and Dentists).

Partnership with the Armed Forces
We recognise the importance that healthcare plays in supporting the country's defence and security, and so we are committed to supporting the UK's Armed Forces community, from cadet adult volunteers to reservists, veterans and their families. We have demonstrated this commitment by signing the Armed Forces covenant. There is significant support from senior leaders as well as management champions, clinical champions and Human Resources who work together to promote the Forces and ensure both staff and patients are supported and not disadvantaged. Some of the ways staff are supported include: -

- Guaranteed interviews for service leavers, veterans and reservists who meet the essential criteria for roles
- Supporting reservists and their managers with mobilisation and demobilisation
- Creation of the Armed Forces staff network.

The core values of the Trust and the Armed Forces are closely aligned, with a focus on people and partnerships, pioneering services and staff pride in what they do. As a result, we strive to ease the path for service leavers to work in healthcare.

Carers
The Carers Network was launched in July 2021 with the aim of supporting unpaid carers working at the Trust. It's estimated that 1 in 3 of the NHS workforce across West Yorkshire and the Humber are unpaid carers. With this in mind, we are concentrating on promoting this group across the Trust to ensure we're wrapping one culture of care around all carers at the Trust. The network focusses on creating a safe space, colleagues' wellbeing, workplace adjustment support and community signposting.

International Colleagues

The International Colleagues Network was launched to provide a safe space for colleagues from overseas to share stories and experiences. Starting a new job is challenging never mind adjusting to a new culture, language, and way of life. The network aims to support international colleagues with the transition into their new role and ensure that their onboarding process is effective. New and established colleagues are encouraged to join the network to create the best learning environment. As well as providing peer support, it is also a way for us to gain insight into what works well and what needs improvements. Alongside the network, there is also a newsletter to update international colleagues with changes and opportunities happening at the Trust.

Equality Delivery System 2 (EDS2)

The Equality Delivery System is designed to specifically support service delivery that is fair, providing equality of access to employment and delivery of services that meets the needs of a diverse population. The Trust and Group introduced the audit tool a number of years ago and annually undertakes a full grading exercise. The outcomes are reported to the Trust Board annually and the equality and diversity action plan is updated as appropriate.

Listening to Colleagues and Support to Speak Up

In September 2021 the Trust employed a new Freedom to Speak Up (FTSU) Guardian. A review of the current FTSU processes has been undertaken with 'fresh eyes' to ensure that the expectations of the National Guardian Office are being met. The review included an update of the Trust's FTSU: Raising Concerns (Whistleblowing) Group policy and the FTSU intranet pages, a review of data collection and the existing promotional resources. As a result, communications have been updated, new lines of communication have been established and promotional resources are in the process of being refreshed.

The Trust has 25 FTSU Ambassadors who come from a range of roles, backgrounds, teams, and Divisions; the ambassadors volunteer to promote FTSU and provide colleagues with a safe space to speak up. In addition to FTSU, there are a number of other routes accessible to colleagues where they can voice their concerns:

- their line managers at one-to-one meetings and/or regular team briefings
- 'Ask Brendan', colleagues can ask our Chief Executive questions via this channel accessible on the CHFT intranet
- the DATIX incident reporting system
- accredited staff side representatives and their organisations
- the Trust's established Equality Networks
- the Chaplaincy team

The Board receives two FTSU reports; a mid-year update report and an annual report both of which inform the Board of FTSU activity, promotional activity, highlights themes, and the improvements that have been made in response to colleagues raising their concerns.

Reporting/Action Plans

The Trust publishes its Gender Pay Gap Report annually on its own website and the designated government website. It has an action plan to address the issues identified. The Trust uses Workforce Race Equality Standard (WRES) and Workforce Disability

Equality Standard (WDES) data to track progress against different metrics to identify and help eliminate any differential in the treatment of staff. Information is presented to the Workforce Committee and action plans are agreed.

Health and Wellbeing

One Culture of Care is at the heart of our colleague wellbeing approach. Accessibility, trust and simplicity have been vital to ensure each one of our colleagues understands that support is available to them should they need it. All the opportunities to access support are communicated via 160 volunteer wellbeing ambassadors in order that they can promote the package locally within their teams. Our focus on positive mental and physical health encourages colleagues to talk openly about their health issues, raise awareness and reduce stigma.

Employee wellbeing has become a particular concern throughout the pandemic. Mental ill health rates are rising; the Office for National Statistics (2021) reports the number of adults diagnosed with depression has more than doubled since before the pandemic. Many people have suffered loss, isolation, illness, and stress during this time, as an inclusive employer the need for an understanding, compassionate, and flexible approach to work is more critical than ever.

We have significantly increased attention on the wellbeing offer and strategy to support the diverse needs of our colleagues with One Culture of Care at the heart of the programme. The Trust appointed a Non-Executive Director as a Health and Well-Bing Guardian during the year.

Through focussing on One Culture of Care for our colleagues and compassionate care for our patients we aim to embed a culture where wellbeing is at the forefront of colleagues' minds, and we aim to become an inclusive employer of choice. There is a balance of support for mental and physical health and wellbeing, we promote the basics

of hydration, nutrition, sleep, facilities, and regular breaks via our wellbeing advisors/wellbeing ambassadors.

We have a wellbeing hour for colleagues which is just one small element of our Health and Wellbeing Strategy. Colleagues have the opportunity to take one hour a week or four hours a month to take time for their self through exercise, volunteering, or developing. This is a clear symbol of our commitment to One Culture of Care. We believe this is vital to keep colleagues well and delivering outstanding performance and make the difference in supporting colleagues through the pandemic and beyond. Colleagues exercise choice to take the hour and work together as a team to make it happen.

Colleague Engagement

Colleague engagement is about listening to and sharing our ideas so that we take action which improves patient care and the organisation that we work in. We have attempted to do this consistently throughout the year with colleagues across hospital and community settings.

Our One Culture of Care approach focuses on caring for each other in the same way we care for our patients. In practice, this emphasises the importance of each and every colleague taking care of themselves and of the people they work with, demonstrating kindness and compassion each and every day.

Our aim is to create a supportive colleague environment that delivers high quality and safe care for our patients and empowers our colleagues as well as giving recognition to the considerable contribution they make.

In the last year, we have engaged colleagues through providing a range of opportunities for them to involved in the design of how “we do things around here”. This is included: -

- Building and supporting colleague networks and highlighting these voices to the senior team, in order that we all understand what is important and develop plans to deliver tangible change.
- Used various channels to engage, promote and encourage participation including an increased utilisation of social media to engage more directly with both prospective and current employees, support the recruitment and retention strategy as well as build a platform from which to promote our one culture of care ‘brand’.
- Hosted regular walkarounds to build relationships with colleagues across the Trust footprint to hear what’s going well/not so well and work with these colleagues to motivate, encourage and support them.
- Listening events were held across the Trust to capture thoughts, feelings, and experiences in order to learn and improve experiences for both patients and colleagues.

It’s important that we acknowledge the excellent work this is delivered by our colleagues and the organisation hosted their annual CHuFT Awards event via a virtual platform, with special guests to present the awards such as the Mayor of Kirklees and Calderdale and the High Sherriff of West Yorkshire. We received 136 nominations, each person nominated received a personalised letter from

the Chief Executive and all shortlisted colleagues were presented with a goodie bag as part of our #CHuFT on the road campaign.

It's important that we recognise colleagues regularly not just once a year at the CHuFT awards event and we issue thank you cards, have a virtual CHuFT recognition platform and we have a monthly star award. Over 2000 thank you cards were issued in 2021.

Development
The Trust's workforce development approach centres on personalised learning, building networks, experiential learning, focussing on unlocking talent, and leadership. Our colleagues are placed at the centre of our programme. This inclusive approach helps the organisation, and our colleagues define the skills and capabilities needed for the future; to provide our colleagues with the tools they need to deliver positive outcomes and identify key gaps in the current workforce; and create innovative strategies and programs to apply those capabilities.

Ultimately our aim is to build a resilient, emotionally intelligent, and inclusive workforce that can bounce back, express compassion, promote positive relationships with One Culture of Care at the heart of everything we do.

Formal Programmes include:

- Talent Toolkit and Framework
- Empower – Inclusive Personal Development Programme
- Stepping into leadership
- Leadership Development Programme
- Management Essentials
- Institute of Leadership and management (ILM) Level 5
- Coaching and mentoring including Executive coaching

Attendance Management
Sickness absence data for 2021/2022 is given below.

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
5,695	65,387	2,078,650	106,072	11.5

Source: NHS Digital - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse
Period covered: January to December 2021
Data items: Electronic Staff Record (ESR) does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year. For the Annual Report and Accounts the following figures are used:

The number of full time equivalent (FTE) days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by average FTE.

The Trust recognises that colleague health and wellbeing is a key determinant of safe and high-quality services. It is a core feature of our people strategy. High rates of absenteeism are costly, from a financial point of view, impact morale levels in the organisation and result in a 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 committed to progressing a range of wellbeing interventions and ensuring access to support that makes a positive impact on the overall colleague experience. In the 2021 National Staff Survey, 60% of colleagues told us that the organisation takes positive action on health and well-being.

Staff Turnover
Staff turnover data for 2021/2022 is published by NHS Digital and the information for the Trust can be found at the following link:-
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Appraisal and Essential Safety Training
The Trust maintained its commitment to ensuring that colleagues were able to discuss their performance, development and health and wellbeing in an appraisal meeting with their line manager. We understand the value of a meaningful appraisal and how important it is to have some time to reflect on what colleagues have achieved and what they want to focus on next, especially around their wellbeing and development. Our appraisal season was due to run from July to October 2021 but, due to the continuing impact of the pandemic and operational challenges on colleagues' time and energy, this was extended to 31 March 2022.

A total of 71.6% of colleagues had an appraisal discussion in 2021/2022.

We also ensure that there is an emphasis on being compliant with essential safety training, mostly through e-learning. Our training ensures that colleagues can demonstrate they undertake their job roles safely and maintain a safe and healthy work environment.

Trade Union (Facility Time Publication Requirements) Regulations 2017

The Trade Union (Facility Time Publication Requirements) Regulations 2017 which implement section 13 of the Trade Union Act 2016 came into force on 1 April 2017. The Regulations require public sector employers (including NHS Foundation Trusts) to publish

the cost of paid facility time taken by employees who are union officials. Employers must report the required information for each 12-month period from 1 April to 31 March on their websites, in their annual reports, and on the gov.uk website. The Trust met this requirement for 2019/20. No penalties or enforcement mechanisms have been set out in the Regulations. The intent is accountability through visibility to stakeholders, the public and the media.

The Trust introduced a Recognition and Facilities Agreement in January 2019 which sets out clear procedures on time off for trade union duties. This recognises the valuable work undertaken by trade unions working in partnership with the Trust. The Trust believes that partnership working brings significant benefits to service users and staff and the spirit of the Agreement is in keeping with these principles.

The Recognition and Facilities Agreement requires trade union representatives to record their time off under these Regulations and they are required to record their time off under the Electronic Staff Record (ESR) Employee Self Service function or e-Roster as appropriate. This in turn facilitates the production of reports on time off for trade union duties. The exception to this requirement to record time off on ESR concerns those doctors undertaking trade union duties such as Local Negotiating Committee work and who have agreed time within their job plans for this purpose.

Time off data for 1st April 2021 to 31st March 2022
This data represents approved time off for trade union duties for medical and non-medical local trade union representatives

Category	Total
FTE days used for trade union duties:	140
Estimated cost of trade union duties:	£50,550.23
Number of staff undertaking trade union duties:	29

Reporting Trade Union Data on the GOV.UK website
The Trust will also publish information on the GOV.UK website as required under Schedule 2 of the Trade Union (Facility Time Publication Requirements) Regulations. The deadline for reporting is 31 July 2022. The unofficial benchmark set by the Government (according to NHS Employers) is 0.06% of the pay bill spent on trade union duties, meaning that any figure above this may attract further scrutiny. The Trust's figures since reporting began in 2018/19 have been 0.02% each year which is well below the benchmark figure.

Gender Pay Gap
Information on our gender pay gap can be found on the Cabinet Office website (https://gender-pay-gap.service.gov.uk/).

The gender pay gap reported is a snapshot position as at 31 March 2021. Our reported position showed the median hourly pay for women as being 19.2% lower than men's. This is an improved position from 20.1% lower as at 31 March 2020.
We have also internally reported our snapshot position for 31 March 2022 and developed an action plan which aims to close the gender pay gap.

Further additional information on the Trust's gender pay gap can be found on our own website at https://www.cht.nhs.uk/publications/gender-pay-gap-reporting/.

Queen's Nurses:

Associate Director of Nursing, Liz Morley; Clinical Manager, Sally Akesson and District Nurse, Ansah Jami were individually awarded the Queen's Nurse for a high level of commitment to patient care and nursing practice

Medical Education Services (including Library and Knowledge Service and Clinical Skills and Simulation) 2021/2022

It has been another busy year for medical education at CHFT.

It has been a successful year for undergraduate medical education student placements. Challenges, of course, have remained around managing placements in the context of Covid restrictions.

However, we have piloted an extension of placement opportunities to Year 1 medical students. This has comprised one half day per week hospital-based clinical placement for a duration of eight weeks. Two cohorts of 10 to 12 students have benefitted from this experience, and initial feedback shared by the medical school has indicated that the students found this to be an excellent introduction to their clinical placement journey. These placements have attracted additional Health Education England (HEE) tariff funding to the Trust.
As at February 2022, our overall undergraduate medical education placement rating stood at 94%. Note that this score is above the All Trust Average (87%), a peer comparison measure.

We have successfully recruited to two new Deputy Director of Medical Education posts. Those post holders are working alongside the Director of Medical Education to forge

developments around improving our educational governance and quality assurance arrangements for our training offer.

We have utilised some HEE Study Leave underspend monies (approx. £24.5k) to facilitate more use of online learning opportunities by our postgraduate trainees. The funding has been used to purchase:

- Laptops for use by anaesthetics trainees
- Laptops for use in the Hub rooms at the newly refurbished Learning Centre at HRI by medical students and postgraduate trainees
- Temporal bone simulation teaching resources (for ENT simulation teaching)
- Electronic journal resources
- Online exam preparation tools

A training needs analysis was undertaken in Summer 2021 to establish the training recovery needs of our trainees and what are the best ways we can remediate for clinical learning experiences that suffered during the pandemic. The learning outcomes from this training needs analysis have informed the priorities of the Training Recovery roles outlined below.

We have also used HEE Training Recovery monies (approximately £60k) to fund the following:

- Post of Training Recovery Lead
- Post of SIM Lead
- Post of Ultrasound Lead
- Educational/Clinical Supervisor training courses
- Trainer/facilitator time to develop in-house capacity for delivery of supervision training

A new Medical Education Manager was recruited in September 2021.

Preparations are underway for the delivery of the CHFT's Got Medical Talent awards for May 2022. We are delighted to celebrate again the wonderful work of our clinicians, especially in the face of ongoing operational challenges relating to the pandemic.

Project work is well underway for development of a new Learning Centre at CRH on Dryclough Close (this is part of the larger reconfiguration project for the CRH site). It is expected that the construction phase of the new build will be completed in Spring 2023.

Refurbishment of the sub-basement area which will house the new Learning Centre facilities at HRI is at an advanced stage. Rooms are being released for use on an incremental basis but it is anticipated that the majority of the works will be completed by early Summer 2022 meaning there will once again be an active Medical Education team presence on site at Huddersfield.
The administration functions for the GP Training Scheme have been taken in-house by HEE. This new arrangement went live on 1st April 2022.

Staffing budget priorities have been revisited and two new apprentice posts will be recruited to in the Spring/Summer of 2022. One will enhance staffing and resources for the reception/medical education assistant function, and for the undergraduate medical

education function. The other will be for the recruitment of a new Simulation Technician apprentice to support this growing area of teaching/training.

Grand Round teaching sessions have been reinstated this year, and we are supporting new areas of teaching development (e.g., a new pilot programme of oncology teaching that is being coordinated by Dr Lucy Jones).

Volunteers

We are incredibly proud to work with volunteers from across our local communities who have continued to support the Trust throughout some incredibly challenging times. We are grateful for their continued involvement and the significant impact that they have on patient care and employee wellbeing.

We have embedded new partnerships including the Prince's Trust, St John's Cadets and others into the Trust so that a more inclusive approach to volunteering can be achieved with the aim of becoming a primary pre-employment access and progression pathway for all. This will help the Trust better serve our local communities, help address inequality and provide additional development opportunities.

Patient Care

Details of work relating to caring, patient experience, continuous quality improvement, quality governance and learning from insight is given below - this includes patient feedback and surveys, patient experience work and quality improvement

More information on quality governance is included within the Annual Governance Statement in the Accountability Report.

The Trust confirms that there are no material inconsistencies between the Annual Governance Statement, the annual and the quarterly Board statements.

Quality and Safety Governance

We continue to use learning from patient and staff experience through continuous testing and measurement aligned to local and national drivers to develop services and improve patient care.

We have continued to work with patients, members, commissioners, regulators and colleagues to identify our patient care and improvement priorities.

Throughout the year the Trust Board received a quality report on progress and activity in relation to a range of quality indicators, including those in the quality account, the quality account priorities and the Trust focussed priorities.

Over the last year extensive work has been undertaken to strengthen the governance and reporting arrangements to ensure that the groups and meetings feeding into the Trust Wide Patient Safety Quality Board and Quality Committee give assurances for effective and efficient reporting to the Trust Board. The Quality Committee receives reports from specialist governance groups e.g., Safeguarding, Clinical Outcomes Group, Patient Experience Group and seeks assurance from divisional Patient Safety Quality Boards about the governance of the quality of their services.

The Quality Strategy has a clear quality governance reporting structure approved by the Quality Committee and the Trust Board. During the year a detailed Quality report has

been presented to each Trust Board meeting which has provided ongoing oversight of the quality agenda and demonstrated that the processes and systems within the Trust to ensure quality and safety are fit for purpose. The report has included assurance on key quality and patient experience outcomes and identified any emerging issues for consideration by the Board.

Work continues to strengthen and streamline reporting into quality meetings to help to reduce duplication; divisions are supported in order to ensure reporting in a meaningful way from “ward to Board” thus giving assurances on the quality of care we deliver. A key element of which is to ensure we are able to share learning across the Trust on areas of good practice as well as learning from when things have gone wrong. Work continues to look at innovative ways of sharing learning and demonstration of change and good quality outcomes.

During 2021/22 we have continued our ward to Board assurance programme, by maintaining visibility of senior leaders and Board members across the organisation within the limits of the pandemic. Whilst quality assurance clinical visits had to be stood down for a period of time, these recommenced in early January 2020.Key areas have also had virtual reviews which included the Emergency Departments and Maternity services. Infection prevention controls walk-arounds and audits have continued to ensure compliance for the NHS E/I infection prevention and control (IPC) board assurance framework which has been refreshed and updated aligned to the updated publications.

The Trust is one of the most digitally advanced in the country and this has been particularly important in responding to Covid-19, enabling rapid implementation of home working and virtual out-patient consultations at scale, enabling continuity and safe delivery of essential services where possible during the Covid-19 pandemic. It also meant the provision of substantial real time data across the organisation which enabled the rapid identification of any issues or trends which warranted further action. This has allowed clinical leaders to see at a glance and in real time the quality of care being delivered.

Ongoing work is planned to further strengthen digital capability to include optimisation of the Clinical Record through in-depth analysis of the current process around electronic documentation, benchmarking and the setting of standards. Use of the Digital White Board had been trialled within the hospital setting with a plan to roll this out to all clinical areas during 2022/23

The Trust has reviewed and revised its Risk Management Strategy and Policy to amalgamate into one Strategy and the Senior Risk Manager’s role has been reviewed and changed to the Head of Risk and Compliance.

The Trust is a key system partner in the West Yorkshire and Harrogate Integrated Care System. Collaborative work has taken place across the system on the approach for the management of Hospital Acquired Covid-19 infection, effective governance and incident management as a whole.

Patient Experience and Continuous Quality Improvement
A structured programme which lends support to the ongoing Trust wide activities has been progressed throughout the year. These support the programme objectives to:

1. Establish and deliver an annual Transforming Patient and Carer Participation and Experience Programme
2. Support the principles of the NHS Long Term Plan (2019) to provide high-quality services that are accessible and convenient for patients and a commitment to prioritising more integrated care
3. Ensure that patient experience and participation is embraced as part of organisational business / activities - Lord Darzi 'High Quality Care for All' (2008) established patient experience as one of the three elements of high-quality care, alongside clinical effectiveness, and safety.
4. Lead an organisational understanding of the relevant legal and policy requirements e.g., Equality Act 2010 and public involvement under the National Health Services Act 2006 (as amended by the Health and Social Care Act 2012).

Key programme priorities have included:

- Commitment to carers
- Reducing noise at night
- Making complaints count
- Embedding a volunteer presence
- Introduction of an understanding people's experiences tool: Observe and Act
- Re-introducing Friends and family test – following a pause through Covid-19

Progress with these projects is detailed below and for each project, actions and plans are in place for the continuation of the project during 2022/23.

This is followed by some examples of how we have responded to patient feedback during 2021/22.

Commitment to Carers
Our Carers strategy was presented and accepted at our Patient Experience and Caring Group (PEG) in March 2022. It is intended to ensure that carers and the role that they have in caring for someone is valued, that they are involved in a way they wish to be involved and supported in their role. It fits with the Trust's vision of delivering compassionate care that puts our patients and community first.:

Our vision is for our staff to be carer aware and understand carers' rights. We will recognise, value, involve and support the role carers play in working with us to deliver patient-centred care. We will also recognise, value, and support the role of carers when they are patients themselves or are our colleagues.

The CHFT Carers Strategy Themes:

The Strategy's themes are taken from the NHS England's Commitment to Carers:

1. Raising the profile of Carers

2. Education, training and information

3. Service development

4. Person-centred, well-coordinated care

5. CHFT as an employer

Objectives of the CHFT Carers Strategy:

- To ensure our staff are ‘carer aware’
- To identify carers and support them with new and changing caring roles
- To value carers in their caring role when the person they care for is admitted to hospital
- To involve carers as valued partners
- To support and signpost carers to sources of support
- To have due consideration for carers when they are our patients
- To have carer-friendly policies and practices in place for our staff

The Trust’s Carers Strategy links with other relevant Trust strategies and policies and will be monitored through the Patient Experience and Caring Group a minimum of 5 times a year.

We have worked with our third sector partners, including Healthwatch to ensure the strategy meets to needs of our Carers.

Our Carers passport will be launched throughout the Trust during Carers Week (6-12 June 2022).

Philip Hutton, who is on kidney dialysis, was the first Calderdale patient to receive a Covid-19 treatment - Philip said, “I felt much safer having treatment at home”.

Reducing Noise at Night

Improvement work continues with clinical colleagues in collaboration with The Professor of Nursing at Huddersfield University to raise awareness about night-time noise levels. This has included the implementation of an educational online resource, posters for wards, ward based 'sleep champions 'who support ward-based initiatives to reduce environmental factors that may disturb sleep and also staff behaviours. All were supported by trust wide communications and awareness raising at key meetings for clinical teams.

There have been two successful sessions evaluating three types of soft closing bins with a range of staff groups to determine structured feedback. Following this Ward 12 at HRI have agreed to be the pilot site to trialling the bins "in situ" to provide feedback from both patients and staff. Work is now ongoing to develop a business case to secure funds to replace the existing bins trust wide.

Making Complaints Count

During the year we have focused on improving the way in which we process, investigate, and respond to complaints. It is important to understand this so that we can implement changes to improve patient care. This was a quality priority throughout 2020/2021 and will continue to be throughout 2022/2023

At the start of the year, we had an ambitious initiative called 'Making Complaints Count', that was designed to align our complaints process with the PHSO standards. However due to the increase in the number of complaints we had from the previous year (+55%), and the operational challenges our clinical teams were dealing with, we decided on a simplified approach, until the basics were done well.

We set up a series of task and finish groups which were attend by a representative from each division. The groups looked at three key areas for improvement which were quality, learning and performance.

- Improving the timeliness of responses for complainants, so we respond in the timescale agreed. We have also ensured lead investigators keep complainants updated about the progress of their complaint and ensuring that processes are in place to escalate any delays.
- Improving how we respond to complaints following feedback we have received from service users.
- Responding quickly and effectively to service users' concerns, so that their problems are resolved and do not develop into a formal complaint.
- Assurance that divisional teams are implementing learning action plans, evidencing changes made and communicating changes made with all appropriate staff, not just management teams.

Embedding a Volunteer Presence

The Trust has successfully implemented a coherent volunteering service that promotes inclusive recruitment, though due to the pandemic we were not able to use volunteers to the same extent as in the past. Through funding secured by NHS England/NHS Improvement (NHSE/I) 'winter and Covid 19 Volunteering programmes' presented us with the opportunity to support the use of volunteers to reduce pressure on our staff and help us to deliver compassionate care for our patients. Volunteers carried out tasks such as support with nutrition and hydration and befriending/ providing patient support.

Observe and Act – Testing and Implementation of Patient Experience Observation Tool

The Observe and Act patient observation tool kit has successfully been implemented over the past 12 months within the adult ward areas within the acute trust. It is now incorporated into the newly devised Journey to Outstanding ward assurance framework. Together they provide a total overview of the ward environment, care delivery and patient experience.

The Observe and Act process is utilising virtual mechanisms and continues to be the only organisation to use this approach in the country. The onsite clinical facilitator is supported by governors, members and Non-Executive Directors who view the environment through a patient's eyes and are involved in discussions with patients and staff members.

Key findings at each observation then drives local improvement at ward level in the Trust.

CHFT have been involved in sharing this concept with the national team and in recent months have been involved in the review work of the existing framework which is being introduced later this year through the national HOPE patient experience platform.

Further steps are being taken to adapt the framework and questions to use in our community hubs and provide patients with the opportunity to share their feedback on experience with community-based care. This is due to be piloted in Spring 2022

Friends and Family Test (FFT)

Data submission and publication for the Friends and Family Test (FFT) restarted for acute and community providers from December 2020, following the pause during the response to Covid-19.

The reporting format has moved away from response rates with a greater focus on driving improvement, supporting comments of what went well and what can we do better will help to inform the improvements.

Consistent with other acute trusts, our response rates are lower than we would expect, particularly for inpatient, community, and maternity services. Low figures relate to staffing pressures and priorities, along with adapting to new processes; higher numbers have been achieved in the ED and Outpatients Departments where SMS messaging is the main method of response.

Various approaches are in place to increase responses: relaunch / improvements to the digital platform, hospital posters with the URL link and QR codes.

Between January and March 2022, we trained our 120 Ward Helper Volunteers in completing the FFT with patients. In addition, we recruited a volunteer specifically to work within low response rates areas.

The learning from our FFT intelligence is now a set agenda item on our monthly divisional Patient Safety Quality Boards and discussed a minimum of five times a year within the Patient Experience and Caring Group (PEG).

Friends and Family Test (FFT): 2021/22 Performance

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
In Patient	96.5%	96.5%	96.9%	96.6%	96.1%	97.3%	98.3%	97.3%	96.7%	97.4%	97.3%	96.4%
Out Patient	92.5%	92.2%	92.3%	91.9%	91.7%	91.5%	91.5%	92.5%	93%	93.2%	92.1%	92.3%
A&E	85.1%	85.9%	83.1%	78.6%	81.4%	80.8%	81.0%	82.3%	84.4%	86.9%	84.4%	77.0%
Maternity	95.7%	88.7%	91.3%	97.3%	95.6%	97.8%	94.2%	93.6%	93.2%	97.6%	91.0%	95%
Community	93.5%	92.7%	93.0%	96.1%	94.9%	96.2%	93.9%	95.6%	93.7%	93.7%	92.5%	94.5%

Patient Experience Surveys

CHFT participates in all the national patient experience surveys. The current position with the surveys is detailed below:

National Children and Young People Survey 2020: Published December 2021, 1065 patients were invited to take part in the survey, 22% of patients took part.

What patients valued:

- Admission dates: patients admission dates were kept the same
- Leaving hospital: patients being told by staff who they could talk to if worried about anything when they got home
- Hospital Wi-Fi: parents/carers feeling that the hospital Wi-Fi was good enough for their child to entertain themselves
- Advice on care: patients being given advice on how to look after themselves after they went home
- Operations and procedures: patients feeling that staff explained what would be done before the operation or procedure

What patients said could be improved:

- Access to facilities: parents or carers feeling they were able to prepare food in the hospital if they wanted to
- Enough things to do: parents or carers feeling that there were enough things for their child to do in hospital
- Play and activities: parents or carers feeling that staff played with their child while they were in hospital
- Hospital food: parents or carers feeling that their child liked the hospital food provided

NHS Maternity Survey 2021 Published February 2022

343 were invited to take part in the survey, 49% of patients took part

W**hat patients valued:**

- The midwife or midwifery team appearing to be aware of the medical history of the mother and baby during care after birth.
- Mothers being able to see or speak to a midwife as much as they wanted during their care after birth.
- Mothers receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.
- Mothers being given enough information on induction before being induced.
- Mothers being offered a choice about where to have their baby during their antenatal care

What patients said could be improved

- Partners or someone else close to the mother were involved in their care as much as they wanted to be during labour and birth.
- Mothers being given information about any changes they might experience to their mental health after having their baby.
- Staff helping to create a more comfortable atmosphere for mothers in a way mothers want during labour and birth.
- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.

Adult Inpatient Survey Published October 2021

1,250 patients were invited to take part in the survey, 40% of patients took part.

What patients valued:

- Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- Taking medication: patients being able to take medication they brought to hospital when needed
- Support from health or social care services: patients being given enough support from health or social care services to help them recover or manage their condition after leaving hospital
- Further health or social care services: patients being given information about further health or social care services they may need after leaving hospital
- Noise from other patients: patients not being bothered by noise at night from other patients

What patients felt could be improved:

- Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went

- Dietary requirements: patients being offered food that met any dietary requirements they had
- Quality of food

Children and Young People's Patient Experience Survey 2020

Patient Perspective were commissioned to summarise of the results of the Children and Young People's Patient Experience Survey 2020. The survey is made up of inpatients and day cases attending the Trust from November 2020 to January 2021.

Of 897 patients invited to take part, we had a response rate of 24%.

What matters the most to patients:

- Fast access to reliable healthcare
- Effective treatment by a trusted professional
- Participation in decisions
- Clear, comprehensive information and support for self-care
- Attention to physical and environmental needs
- Emotional support – empathy and understanding
- Involvement from family members and Carers
- Continuity of care and smooth transitions

Responding to Patient Feedback

The Trust has many ways of seeking patient feedback. Below are some areas where patient feedback in 2021/22 has led to changes in our services and the actions the Trust took in response to this feedback.

'You Said'	'We Did'
You wanted to know how long you might have to wait to be see in the Emergency Department	We improved our signage that explains about how we prioritise patients. We also have digital display boards that show the waiting times for triage and for treatment.
At times you found it difficult to sleep on our maternity wards	Staff on our maternity wards have now completed 'Noise at night' awareness training. This has been rolled out to over 70% of our clinical staff, so patients across the trust can benefit from an improved sleep experience.
Our oncology patients didn't want to go through the Emergency Department (ED) every time their condition worsened.	We set up a dedicated Oncology and Haematology Patient Line which is manned 24/7. Following triage, any patients that need to be admitted can now go straight to the ward, meaning then no longer need to go through ED. Approximately 80 patients a week are using this service.
Children told us they wanted a better choice of meals	We now have new child friendly meals which have healthy options. This was done as a co-design approach with young people involved in the decision-making process.
At times you felt lonely, especially when you were on the side wards	We improved the role of our Care Club Volunteers so they could provide befriending service to our

	patients. During 2021/2022 over 100 new Volunteers were recruited across the Trust.
You needed information on what to do and who to call when someone dies in hospital	In February 2022 we issued an up to date 'When a loved one dies' booklet. This gives you the most up to date information what happens next, contact details of local support groups, and practical tips that may help you at such an upsetting time.

Other Initiatives: Enhancing the Experience of Patients and Carers

In addition to the Trust wide priorities, various initiatives and improvements have been delivered through the corporate services and divisional teams, many relate to the impact of Covid-19 on patient experience and the approaches taken to overcome them. These are described below and have been mapped to show how they support the delivery of the responsive and caring domains within the CQC framework, and the key lines of enquiry related to these domains.

Compassionate care (caring):

- **Relatives Line**:

The relatives' line was set up is a single point of contact, which provides relatives and carers detailed updates of their loved ones. This was in response to the covid 19 pandemic, a time when the Trust was unable to accept visitors into our hospitals. The service went live to callers from April 2020. The service continues to be a valuable resource, and we anticipate this to continue whilst visiting restrictions are still in place.

The telephone lines are operated by clinical staff, who can access electronic patient record (EPR) documentation, the qualified staff member can then deliver a comprehensive update to the caller, including treatment and management plans. The platform can also be used to communicate important information to the ward staff and wider multi-disciplinary teams.

In total the service has received over 98,000 calls

The relatives' line was successful in winning the regional NHS Parliamentary Award under the caring and compassion category. The final was held on the 7th July 2021 in London, were it received- ' Highly commended ' in the care and compassion category.

The relatives' line and virtual visiting service were also nominated for HRH The Prince of Wales award for integrated approaches to care

- **Emotional support (caring):**

The bereavement support service continues to support relatives that, due to restricted visiting, may not have been able to spend the last days and hours with their loved one. A bereavement box with a handwritten bereavement card, bereavement support numbers, a knitted heart and marigold seeds have been sent out to the next of kin of everyone who has died since 23 March 2020. At around 7-10 days, a call is made to the next of kin to check how they are and offer any support. Feedback has been good and bereaved relatives are appreciative of the call and the box.

- **End of Life Care**

Improving End of Life Care (EOLC) continues to be a priority area for the Trust, and regardless of where patients die or when they die, it is vital that they receive appropriate and high-quality end of life care. During Covid-19 there was concern that patients maybe dying alone with no family by their side and that this may cause lasting distress and unresolved grief. Therefore, the Trust looked at what extra we could do to support all our bereaved families. The End-of-Life Care Team developed a new bereavement support service for relatives of all adults (over 18) that die in the Trust. which include telephone support calls to bereaved families. This service was shortlisted for a Nursing Times The Trust has also implemented a 7-day service across community services.

Thinking Ahead

Kathy and Peter Daveney promote the Thinking Ahead Programme run by the Macmillan Information service to encourage early conversations about end of life planning.

Responsive

- **Virtual Visiting**:

From June 2020, virtual visiting has been made available to help connect our patients and loved ones; ensuring they can contact each other in a safe environment.

This is done using an android tablet through Microsoft Teams. Staff help patients use the equipment, as we recognise, this could be daunting, especially for those who may not have used technology in this way before.

Each call can last up to a maximum of 30 minutes, with 15 slots within a working day. These are made and allocated by appointment only. To date the service has facilitated over 16,000 virtual visits.

In light of national guidance, the Trust's visiting approach in maternity services was impact assessed and revised arrangements put in place to support families during birth.

- **Letters to a loved one**

Relatives, carers and loves ones have been able to send electronic letters to patients since May 2020. This is done through a dedicated inbox.

To date over 5,000 letters have been delivered to patients through our virtual service.

- **Every Story Matters**

The Trust recognises that not every issue raised by patients is a complaint, PALS issue or concern. Often there is a real opportunity to learn through feedback shared in an alternative format. Therefore, Trust has developed a mechanism for 'Patient Stories' to be captured, heard and developed into a tool for learning. These are presented at our Patient Experience and Caring Group bi-monthly.

- **Use of digital platforms**

There has been rapid acceleration in use of digital appointments to ensure patients can access effective care during the Pandemic, this process will continue to enable all our patients to have access to care in a timely manner.

Fourteen Clinical Assessment Services (CAS) have been implemented and these new pathways provide more streamlined review of patients and reduce the need to attend hospital. The Trust is currently progressing these and aims to see rapid expansion of Patient Initiated Follow-up models of care which aims to optimise use of the Patient Portal to enable more self-care

The Trust has actively participated in National Getting It Right First Time (GIRFT) Programme which is designed to improve the quality of care within the NHS by reducing unwarranted clinical variations

- **Maternity services Ockenden report**

Maternity services submitted evidence against the seven Immediate and Essential Actions of the first Ockenden report published in June 2021. The final report into maternity was published in March 2022. There are 15 Immediate and Essential Actions described in the report and maternity services have undertaken a robust self- assessment of their current position and will develop a robust action plan to achieve compliance with this The service continues to work towards achieving full compliance with the action of the first Ockenden report, with regular update reports provided to Quality Committee and Trust Board for assurance.

Health Inequalities

The increased focus on health inequalities since the onset of Covid- 19 has provided an opportunity for the Trust to develop its information systems to capture relevant patient information and to analyse this data to inform service planning and make progress in reducing health inequalities locally. Areas of focus to date have included:

- analysis of access to A&E and priority category and waiting lists by index of multiple deprivation and ethnicity
- data analysis which led to a decision to prioritise treatment for patients with learning disability
- focus on the implementation of the continuity of care standard for maternity services for BAME mothers.
- Improving the experience of patients with visual impairment - for organisations (Disability Partnership Calderdale, Halifax Society for the Blind and Kirklees Visual Impairment Network) have worked collaboratively to review feedback from service user engagement events

Concerns, Complaints and Compliments – 2021/22

Due to the ongoing Covid-19 pandemic NHS England and NHS Improvement supported a system wide "pause" of the NHS complaints process from 26 March 2020 to 1 July 2021. Complaints were still being received into the Trust during this period. However, the population we serve were cognisant that there was an understandable emphasis on directing all available clinical resources to fighting the pandemic and recognised that there may be delays in the investigation of their concerns

Complaints and concerns remain an important focus area for the Trust. And we are committed to learning from concerns and complaints so that we can:

- Improve the quality of care our patients, carers and their families receive.
- Improve the services that we offer.
- Improve the experiences of our colleagues in line with the Trusts One Culture of Care.
- Share good practice.
- Reduce the number of complaints.

When considering learning from a complaint, we ask that each service and division is clear about:

- How the service records learning from complaints.
- How this learning is disseminated within the Trust.
- How it can point to the impact and outcomes arising from learning from complaints

All formal complaints are dealt with in accordance with the Local Authority Social Services and NHS Complaints (England) Regulations 2009. Formal complaints are typically detailed, identifying problems and issues relating to episodes of care that have already happened (for example, questions as to why a diagnosis was not made at an earlier time). All complainants are contacted by the lead investigator following the acknowledgment of their complaint in order to discuss and agree the issues that they wish to be investigated and addressed. A full investigation is undertaken, and a written response is then provided. The response details the investigation outcome, along with any learning points and actions that have been identified.

In contrast to formal complaints, concerns often consist of one or more problems that have recently happened and can be addressed and resolved verbally, or future problems that need resolving quickly. Examples of concerns are dissatisfaction with

signage for Covid-19 testing, or an appointment that was expected but has not yet been received.

A large amount of positive feedback is also received. Compliments received by the Patient Advice and Complaints Service are shared with the relevant specialty and are logged as such on Datix. Compliments are also regularly received directly by a service and shared appropriately. All compliments are valued by staff and are a useful source of intelligence on what the Trust is doing well.

During the year we have focused on:

- Improving the timeliness of responses for complainants, so we respond in the timescale agreed. We have also ensured lead investigators keep complainants updated about the progress of their complaint and ensuring that processes are in place to escalate any delays.

- Improving how we respond to complaints following feedback we have received from service users.

- Responding quickly and effectively to service users' concerns, so that their problems are resolved and do not develop into a formal complaint.

- Creating a 'Making Complaints Count' Improvement Collaborative with expertise across the divisional and corporate teams to help deliver long term and sustainable improvements to complaints handling within the Trust.

- Ensuring that the considerable operational pressures from the Trust's Covid-19 pandemic response had as limited an impact as possible on those patients and family members contacting the Patient Advice and Complaints team to raise concerns during those periods of peak pressure from the virus. However, we also recognise that it was not possible to mitigate the impact entirely and the patience shown to the team by the public during the difficult periods of the pandemic has been much appreciated.

Complaints and PALS Performance during 1 April 2021 to 31 March 2022 for the Trust:

490 **Formal complaints**	This is a significant increase from 2020/21 (316). This is likely to be attributable to operational demands on services and in-patient wards as a direct result of the effect of the Covid-19 pandemic resulting in more patients and families raising complaints about their treatment, care and waiting times.
59% **Complaints closed within target timeframe**	This figure represents a slight decline in performance of complaints responded to within the target timescale compared to 2020/21 (63%). However, it is recognised that more work needs to be done to drive further improvements. This is being addressed through quality improvements initiated via the Making Complaints Count Collaborative and through close monitoring of, and support for, timely performance at divisional and corporate levels.
1788 **PALS Concerns**	This figure represents the number of PALS concerns received during this period and is similar to the year before which was 1774.
654 **Enquiries/suggestions and improvements**	This figure represents all other contacts and enquiries the PALS team receive which has seen an increase from 570 in 2020/21.
608 **Compliments**	Total number of compliments received during the year which is an increase from 2020/21 (496)

National Development

The Parliamentary and Health Service Ombudsman (PHSO) have been working with the NHS and other public service organisations, members of the public and advocacy groups to develop a shared vision for NHS complaint handling.

The new PHSO Complaint Standards Framework sets out a single set of standards for staff to follow and provides standards for leaders to help them capture and act on the learning from complaints.

The PHSO has introduced some internal changes in relation to how they manage and handle their referrals. Any impact from this change is likely to emerge within the next financial year.

Forward Plan for 2022 / 2023

The Trust continues to build a complaints team and service via integrated ways of working in order to meet regulatory standards, Trust priorities and the needs of our communities.

Care Quality Commission Compliance
The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Assurance on compliance with CQC requirements is achieved through the governance structure via a monthly CQC and Compliance Group and regular reports regarding CQC which are provided to both the Quality Committee and the Board.

A well-led inspection completed by the CQC in April 2018 focussed on the Trust's integrated governance and leadership across quality, finance, operations, organisational culture, improvement, and systems working. These are consistent with the well-led framework from NHS England and NHS Improvement. The Trust received an improved overall rating of "good" by the CQC, with a "requires improvement" rating for Use of Resources. The Quality Committee oversees the Trust's progress with one ongoing action from the CQC well-led inspection report, with Use of Resources also reviewed by the Finance and Performance Committee. This Committee has signed off completed action plans for all the 'should do' recommendations received under the Use of Resources assessment and receives regular updates on the overall financial sustainability of the organisation where continued improvement against key performance indicators has now been delivered for a number of years.

The combined rating for quality and use of resources is good. With regard to the NHS E/I well-led framework, the "good rating" from the well-led inspection and progression of remaining action from the CQC inspection support the Trust in improving the governance of quality.

The pandemic has changed the way in which CQC regulates providers and there is no longer a set annual on-site inspection plan. Instead, the Trust has and continues to comply with CQC's revised approach to regulation in line with the development of their future strategy and ensures regular engagement with the CQC via the Relationship and Inspection Manager.

NHS System Oversight Framework

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.

NHS Improvement's (NHSI) System Oversight Framework (SOF) provides the framework for overseeing providers and identifying potential support needs.

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 framework assesses providers' performance against five national themes:

1. quality of care, access and outcomes
2. preventing ill health and reducing inequalities
3. finance and use of resources
4. people
5. leadership and capability

Based on information from the five national themes, NHSI segments providers from 1 to 4, where "1" reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has found to be in breach or suspected breach of is licence. 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 NHS E/I'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).

Finance and use of resources metrics

During 2020/21 and 2021/22 the monitoring of the use of resources (UOR) score has been suspended by NHS Improvement in recognition of the different operational and financial position driven by the Covid-19 pandemic. In the last year of monitoring, 2019/20 the Trust had a UOR score of 3 on a scale of 1(best) to 4. An improved UOR score of 2 is the Trust's position as at March 2022. The Trust has continued to monitor internally to provide assurance against this metric.

During 2020/21 existing Department of Health and Social Care (DHSC) interim revenue and capital loans of £141m were extinguished and replaced with the issue of Public Dividend Capital. This is expected to have a positive impact on the UOR score in future periods if the monitoring is reinstated.

In January 2015 Monitor / NHS Improvement (the regulator of Foundation Trusts at that time) declared the Trust to be in breach of licence as a result of an unplanned year-end deficit position of £4.3m and set out the undertakings it expected of the Trust. NHS Improvement issued the Trust with a certificate of compliance for two of the three undertakings relating to Board governance and effectiveness and general action.

The remaining undertaking requires the Trust to 'ensure the Licensee's clinical and financial stability is maintained from the end of the financial year 2016/2017'. The Trust's reconfiguration business case represents the planned route to financial stability, and this continues to be progressed through the stages of approval to secure funding. In the meantime, the Trust remains in an underlying deficit position and reliant upon Financial Recovery Funding, which is now embedded within the Integrated Care System funding allocation and the Trust's income, to sustain service delivery. Therefore, NHS Improvement has not certified compliance with this final undertaking.

The Trust has however, delivered financial performance in line with agreed regulator expectations in each of the last five years. The Trust Group's adjusted financial performance (as measured by NHSI) was a surplus position in every year from 2019/20 through to 2021/22. Challenging and transformational Cost Improvement Programme

schemes have been delivered and the plans for the reconfiguration business case continue to be progressed.

Professor Brendan Brown
Chief Executive

5 July 2022

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Calderdale and Huddersfield NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Calderdale and Huddersfield NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual)* have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to

make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Professor Brendan Brown
Chief Executive

5 July 2022

Research 600th RECOVERY Trial recruit

CHFT was in the top 20 recruiting Trusts and remains the highest recruiting Trust in the Yorkshire and Humber region for the Randomised Evaluation of COVID 19 Therapy (RECOVERY trial)

ANNUAL GOVERNANCE STATEMENT 2021/22

1. 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.*

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Calderdale and Huddersfield NHS Foundation Trust (CHFT), to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in CHFT for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts.

3. Leadership for risk management and capacity to handle risk

As Accountable Officer I am responsible for overseeing risk management across the Trust's clinical, financial and organisational activities, with the Board of Directors and responsible for reviewing the effectiveness of the system of internal control, supported by Board Committees. This includes meeting all statutory requirements and adherence to guidance issued by NHS England/ NHS Improvement.

The Board approved Risk Management Strategy and Policy clarifies accountability and, delegated responsibility for risk and the reporting arrangements for the management of risk within the Trust and the wholly owned subsidiary Calderdale and Huddersfield Solutions Limited (CHS). The Risk Management Strategy and Policy:

- aims to promote a positive culture towards the management of risk and minimise risk to all of its stakeholders
- sets out the responsibility of the Executive Directors, senior managers and specialists in respect of leadership in risk management
- details the Committee governance structure that supports decision-making for key organisational risks
- confirms the roles and responsibilities of all staff in relation to the identification, management and control of risk
- defines the framework, processes and policies in place to pro-actively identify, manage and eliminate or reduce risks to a tolerable level and maintain sound internal control.

As Chief Executive with overall responsibility for the management of risk, I am supported in this by a Director team which exercise lead responsibility for the specific types of risk as follows:

- The Executive Director of Nursing / Deputy Chief Executive is the Executive lead for risk management and patient safety in partnership with the Medical Director. They ensure organisational requirements are in place which satisfies the legal requirements of the Trust for quality and safety, patients and staff. This includes the implementation of processes to enable effective risk management and clinical standards.

- The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within the Trust and actions to control these.

- The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.

- The Director of Workforce and Organisational Development is responsible for workforce planning, staffing risks, staff health and well-being, training and health and safety.

- The Managing Director for Digital Health has responsibility for managing IT risks including information governance, electronic patient records and has delegated arrangements in place to the Head of Informatics as the Senior Information Risk Officer.

- The Director of Transformation and Partnerships has responsibility for managing risks in relation to service reconfiguration and transformation and partnerships.

All Directors report to me and I hold them to account for their performance individually and as a team to deliver the objectives of the Board and ensuring that a strong risk management approach is embedded in all clinical and non-clinical activities of the Trust.

The Board has set out the minimum requirements for staff training required to control key risks through a mandatory training programme. Staff are trained and equipped to manage risk in a way appropriate to their role, through targeted training, for example risk register training and investigation training.

A range of policies are in place and available to staff via the Trust's intranet which describes the roles and responsibilities in relation to the identification, management and control of risk. The risk management team provides additional support, guidance and expert advice to staff on risk management.

Lessons learnt when things go wrong are shared through directorate governance systems through various dissemination methods including newsletters and bite size learning.

4. The Risk and Control Framework

The Trust works within one culture of care, providing compassionate care for both our patients and staff, manages premises and finances and understands that these activities have an inherent degree of risk that cannot be eradicated.

The Trust's Board approved Risk Management Strategy and Policy and risk appetite guides staff in managing clinical and non-clinical risk which requires commitment, collaboration and participation from all members of staff.

The Risk Management Strategy and Policy confirms the Board Committee structure that provides assurance on and challenge to the Trust's risk management process. Board Committees are chaired by a Non-Executive Director providing independent scrutiny and these are key in ensuring quality, safety and management and monitoring of risk throughout the Trust, with independent assurance through reports from the Committee Chairs to the Board of Directors. The Board Committees have oversight and scrutiny responsibility for safety and risk within the remit of their terms of reference, with the Non-Executive Chair reporting on assurances or escalating matters as necessary. Board Committee responsibilities for risk management are summarised in the Board and Committee structure section of this statement.

The Risk Management Strategy and Policy provides the framework for pro-active risk identification and management of risk, through risk assessment, risk registers, compliance registers and the Board Assurance Framework (BAF), with consideration of this through the governance structure, which was revised as part of a review of the Risk Management Strategy, which is combined with the Risk Management Policy, and refreshed during the year. It sets out how risks are pro-actively and systematically identified and evaluated using a risk assessment matrix to assess potential impact and likelihood of a risk, controls for managing risks, as well as actions to address any gaps in risk control treatment. The Risk Management Strategy and Policy provides guidance for staff to help identify, assess, score, action and monitor risk and when to escalate risks.

Each division and directorate are responsible for maintaining their own risk register, ensuring that risks are identified from the bottom up. These risk registers are reviewed regularly by directorate and divisional forums and specialist risk groups such as the Health and Safety Committee. Where a risk rating warrants it, risks are escalated for consideration for inclusion on the high-level risk register. This high-level risk register details significant operational risks, the controls in place to mitigate and manage the risks and provides assurances that the controls are effective. It is reported to formal meetings of the Board.

The Risk Group comprises both senior clinical leadership and senior management representation from all divisions. This group reviews the Trust's risk profile and oversees all risk management activity, including the high-level risk register and reports directly to the Audit and Risk Committee. The Risk Group also reviews the Board Assurance Framework to ensure that there is linkage between this and the high level risk register.

The governance framework in place for the Trust's wholly owned subsidiary CHS details how risks are managed and reported within CHS via monthly Board meetings and the Joint Liaison Committee between CHS and the Trust.

The Trust is a key system partner in the West Yorkshire Integrated Care System (ICS) and the Trust Chair and Chief Executive have actively participated in West Yorkshire Health and Care Partnership Board meetings during the year, with the Trust Chair having chaired the Partnership Board for six months of the year. The Chair has also been actively involved in the ICS Chairs and Leaders Reference Group developing future governance arrangements for the ICS as it prepares to move to a statutory footing during 2022/23.

The Trust is an active participant of the West Yorkshire Association of Acute Trusts (WYAAT). Risk registers are maintained for individual WYAAT programmes with oversight of programme delivery and management via the agreed WYAAT governance arrangements with regular reports on these provided to the Trust Board during the year. Further information on partnership working with WYAAT is detailed in the Transforming and Improving Care section.

The risk and control framework for the management of Covid-19 risks is detailed below.

Risk and Control Framework for the Management of Covid-19
The Trust has had a Command and Control Structure in place during the year which provided a robust and transparent method of mitigating, preparing and responding to the differing waves of the Covid -19 pandemic. These management and governance arrangements ensured emergency planning arrangements were in place, with oversight of the Trust's operational position and delivery of needs-based care, with daily escalation of performance issues from divisional hubs into Covid-19 tactical (daily meetings) with daily gold meetings, where needed, to manage increased pressures. Covid-19 related risks were added to the risk register and considered through established risk governance processes in line with the Risk Management Strategy and Policy and included in the Trust's high level risk register escalation and monitoring process where appropriate.

The Command and Control arrangements were reviewed in February 2022 and strengthened with terms of reference and structured agendas for bronze, silver and gold command meetings from April 2022. During 2022/23 there will be revised on-call arrangements implemented in a phased approach aligned to site management changes.

The Trust also contributed regionally and nationally to manage the ongoing pandemic through collaboration with local partners across West Yorkshire.

Embedding risk within the Trust
In addition to risk registers and the Covid-19 pandemic risk and control framework, other ways risk management is embedded within the Trust include:

- delegation of operational responsibility for risk management to individual teams
- an open reporting culture and encouraging staff to report incidents through the electronic incident reporting system Datix
- policy, guidance and training provided to staff on the reporting, management and investigation of incidents

- equality impact assessment (EQIA) - EQIA is part of Trust core business, is considered in all Board and Committee papers and has been a focus of continuing Board monitoring and improvement. An equality impact assessment process and quality impact assessment process for proposed service changes is in place with detailed guidance to support staff to ensure the Trust considers the impact on a diverse range of people and ensures we maintain high standards of quality.

Risk registers continue to be used to support capital planning to understand the clinical and operational risk of schemes proposed, thereby informing decisions about which schemes are progressed.

Principal Risks and Opportunities
The Trust Board agreed a ten year strategy in July 2020, together with annual objectives to support the delivery of the strategy. Progress on the completion of these objectives was reported to the Board in November 2021. The Covid-19 pandemic impacted on annual planning timescales and the Board agreed a set of strategic objectives for the period November 2021 to March 2023 that will support continued progress to deliver the ten year strategy. An update to the Board on these was given at the Board meeting on 3 March 2022.

The principal risks to delivery of the Trust's strategic objectives and mechanisms to control them are identified through the BAF and monitored through lead Directors and the Board Committee structure, with high level operational risks which could impact on these risks entered onto the high-level risk register.

During 2021/22 the Covid-19 pandemic continued to present a major challenge, with operational activity adjusted according to the local impact of the different waves of the pandemic and the availability of the workforce. Significant focus was given to capacity, including securing additionality and recovery of activity. Leadership by the Director team with support from the Non-Executive Directors, to maintain a sound system of internal control has been key to the Trust's response to managing the crisis and associated risks.

The impact of Covid-19 on Trust activities was reflected by operational risks being added to local risk registers and the high-level risk register. Changes in risk scores to existing strategic risks on the BAF were made, reflecting the inability to progress aspects of risk mitigation due to managing the pandemic.

As a part of the Trust's overall approach to continuous improvement, it uses a methodology described as the 3R's (i.e., Reality + Response = Result). There are four Result areas across both the ten and one year strategies and these are identified below. Within each of these Result areas, risks and opportunities for 2022/23 are identified below, structured around the Trust's four pillars of behaviour.

Transforming and Improving Patient Care:

Learning from the Pandemic –- through the involvement of colleagues, system partner organisations and members of the public 12 'Business Better Than Usual' learning themes identified have been progressed during the year so that new ways of working implemented during the pandemic, which have potential long-term benefit, are sustained and are now within mainstream transformation work. Examples include

integrated models of care in the community, direct assessment pathways and digital options for visitors.

Service Reconfiguration - the limitations and constraints of the existing hospital estate facilities at the two sites have created additional risks to service delivery during the pandemic. The Trust has continued to drive transformation by progressing the reconfiguration of service across the two hospital sites and community to enable improved clinical quality and outcomes, improved efficiency, improved compliance with statutory, regulatory and accepted best practices, better use of the available hospital estate and mitigation of the significant estate risks related to the age and condition of Huddersfield Royal Infirmary (HRI) and improved sustainability supporting progress to net zero carbon. With planning and finances agreed, work on the build of the new Accident and Emergency Department at HRI began in 2021, for completion in 2023. Completion of the hospital build at Calderdale Royal Hospital (CRH) in 2026 remains on track, subject to Treasury approval of the Reconfiguration Outline Business Case (OBC) expected in 2022.

Progress with implementation of the Trust's clinical strategy with partners - The Trust continues to be an active partner within the ICS and WYAAT. A partnership board has been established with the Mid Yorkshire Hospitals NHS Trust to strengthen services and offer mutual support. A Diagnostics Board has recently been established to progress the Radiology and Pathology networks and work progresses on the implementation of a Pathology laboratory information system. The Trust attends clinical and professional forums in both Calderdale and Kirklees PLACE. The Trust supports the provision of non-surgical oncology (NSO) services in both Bradford Teaching Hospitals Trust and the Mid Yorkshire Hospitals Trust, whilst a longer term sustainable service model for the region is agreed. An independent report on NSO has recommended a two-hub model with the Trust as one of the proposed hubs. Work continues to secure agreement across WYAAT on the future service model.

Digital Capability - the Trust is one of the most digitally advanced in the country. The Trust continues to make positive progress with its Digital Strategy to improve the digital functionality and maturity of the healthcare environment and during 2021/22 has been part of the national Digital Aspirant Programme, progressing a number of our digital ambitions.

The Trust is seeking to be a leader in data aggregation and data intelligence in 2022/23 to better serve our patient, staff and external stakeholders. This includes completing our links to the Yorkshire and Humber Care Record, the construction of a cloud-based data aggregation platform and working with our vendors to create a universal single source of truth across all our applications. This will be supported by an agnostic integration platform enabling the Trust to work within the broader PLACE and ICS framework to share data and improve patient pathways.

Keeping the base safe

The Trust has continued to face operational pressures and risks to the quality and safety of care provided as a result of the ongoing pandemic, which are detailed below.

Risk of adverse impact on health outcomes for patients and the potential for harm related to delays due to prolonged waiting times as a consequence of Covid-19 restrictions for access to planned care - there is a risk to the timely treatment of patients

due to the continuing impact of Covid 19 on our population and service delivery. The Trust has faced challenges managing high levels of demand and high acuity / dependency of patients leading to longer lengths of stay, with limited capacity, due to responding to the pandemic and the requirement to maintain infection prevention and control (IPC) measures, with a peak demand for covid positive inpatients in January 2022. The long term impact of Covid-19 infections on patients and the response to this remains uncertain.

Capacity to manage demand - decisions to stop elective work during earlier phases of the pandemic have impacted on the number of patients and the length of time waiting to receive care and treatment. Patients on waiting lists have been prioritised according to clinical need. The Trust continues to focus on the recovery of elective care services by maximising elective in patient and out-patient activity and reducing long waits, including use of insourcing and outsourcing of services, to minimise risk to patients of further delays for treatment. A recovery plan is in place, based on principles agreed by the Board of Directors, and progress has been monitored via a Recovery Oversight Group and the Finance and Performance Committee. During 2022/23 there will be strengthened governance arrangements to monitor recovery via a new group focusing on Access and reporting into the Finance and Performance Committee monthly. There remains the potential for future Covid-19 variants to impact on operational delivery during 2022/23.

Diagnostics, a key part of many elective care pathways, is a key risk to elective recovery, with MRI waits over six weeks a particular concern. An MRI backlog recovery plan is in place requiring an additional mobile scanner and installation of two new MRI scanners, expected in quarter 1 of 2022/23. Echo diagnostics and neurophysiology diagnostics are also a challenge, with mitigation in place. Theatre capacity also presents a risk to achieving elective recovery targets, with a focus on improvement work to increase efficiency in theatres and development of different care pathways, for example patient initiated follow ups.

Needs based prioritisation to address inequalities and variation in care provision - the Trust has been at the forefront of development of expertise in health inequalities data capture and analysis. During the year real time data analysis of patient waiting lists in relation to index of multiple deprivation, ethnicity and other protected characteristics has been used to inform prioritisation of care. This will continue into 2022/23 to continue to reduce health inequalities amongst our communities.

Risk of negative impact on patient experience - there continues to be a risk that patient experience could be negatively impacted due to significant and sustained increase in demand for our two Emergency Departments, with challenges meeting emergency care targets for waiting times.

Patient flow - the Trust has experienced risks to maintaining patient flow throughout the hospital, with significant bed pressures due to the increased Covid bed base. Patient flow through the health and social care system has also been challenging in terms of supporting the timely discharge of patients from hospital, associated with challenges in the health and social care community. Work with partners across the system has taken place, providing an opportunity for whole system partnership working to respond to operational pressures. Delayed transfers of care continue to present an operational risk.

Infection Prevention Control (IPC) - preventing in-hospital Covid-19 transmission has been a top priority during the year and strategies have been in place to minimise health

care onset Covid-19 infections (HOCIs), including Covid patient pathways, to minimise risk. The Trust is compliant with national guidance which has remained under continuous review and has been modified as the pandemic and evidence base has developed. There are clear governance processes in place for HOCI with root cause analysis undertaken and lessons learned identified to support organisational learning.

IPC measures and their associated risk assessments are being reviewed to ensure that any constraints to the delivery of elective activity are minimised. This includes revisions to minimal social distancing requirements and isolations and testing regimes for low risk elective activity.

Workforce

Workforce capacity and resilience - this has been a significant challenge during the year. This is partly due to a national workforce shortage in key professions across the NHS which affects our ability to attract, recruit and retain a substantive workforce to deliver safe, high quality care for our patients. The vacancy position in the substantive medical workforce has improved significantly over the last year, however, there remain significant workforce pressures in Stroke, Neurology and Neurophysiology. Whilst the Trust has made good progress with recruitment to substantive nursing vacancies, nursing workforce availability was impacted by staff absence and reduced availability due to either Covid-19 or self-isolation. Like other Trusts in the region, the latter part of the year saw the most challenging workforce position on colleague availability across all clinical divisions, with exceptional levels of colleague sickness or absence due to isolation. This peaked in January 2022 reflecting local transmission rates of the Omicron variant. Daily workforce control and escalation has been in place to mitigate the risks to safe staffing levels and further information regarding this can be found later in the Workforce Strategies and Safeguards section of this statement. The Trust will continue to focus on retention and recruitment to vacancies during 2022/23.

Health and Well-Being - the Trust continues to recognise the importance of supporting the health and well-being of our colleagues during the sustained pressures of the pandemic, with a focus on One Culture of Care, caring for colleagues the same way we care for our patients. The Trust continued to invest in the health and well-being of our colleagues in a variety of ways, including supporting and managing mental wellbeing and access to a Wellbeing sessions programme, local support networks, accessing well-being time, self-care resources and development programmes and opportunities for talking, counselling and emotional and psychological support.

The pandemic gave us an opportunity to rapidly review the way we work and offer some innovations in service delivery models, our aim will be to continue to develop some of these including virtual appointments, virtual visiting and empowering patients to manage and monitor their own conditions.

Risks and opportunities relating to financial sustainability are detailed below.

Financial Sustainability

The Trust 2021/22 financial plan and in-year reporting was adapted to reflect the national changes to the NHS financial funding regime during the year. Funding was managed within an agreed overall financial envelope across the West Yorkshire

Integrated Care System, this incorporated specific funding awarded for Covid-19 costs. Additional funding was also available to address the requirement to catch up elective activity paused during the pandemic period.
The future continues to pose risks and opportunities for financial sustainability. These are outlined below:

- Exit from Covid-19 costs will have to be managed alongside a clinical activity backlog and recovery of services to deal with this. There is Elective Recovery Funding available to address backlogs. This presents an opportunity but also poses a financial risk as activity thresholds must be met to access this funding.
- The Trust entered the pandemic with an underlying financial deficit position and this structural challenge remains. However, the system funding envelope has the previous level of Financial Recovery Funding which supported this position embedded within it.
- The extinguishing of £141m of revenue and emergency capital borrowing in 2020/21and replacement with non-repayable Public Dividend Capital strengthens the Trust's position going forwards.
- The financial position in 2022/23 requires renewed financial focus and a requirement to identify efficiencies. The Trust has reviewed its approach to traditional Cost Improvement Programmes (CIP) and has reinvigorated an approach that engages colleagues and seeks to drive transformation. In support of this, the Trust has a previous track record of successful delivery of efficiency programmes over a number of years.
- Current provision of dual services across two sites is a less efficient model, due to duplication of costs and the additional difficulties this presents in relation to recruiting and retaining staff.
- The Trust's estate presents financial challenges due to upgrade requirements and Private Finance Initiative contractual commitments.
- The Trust's plans for service reconfiguration continue to be progressed subject to approval of the reconfiguration Outline Business Case in 2022. The plans will secure much needed investment in our estate and enable new ways of working that will generate efficiency.
- National changes to NHS structures and associated financial funding flows mean that the environment is changing with an ever-greater opportunity to work together across the Kirklees and Calderdale PLACEs and with other organisations across the West Yorkshire Integrated Care System.

Financial risks are identified and escalated for detailed scrutiny by the Finance and Performance Committee with high level strategic financial risks forming part of the Board Assurance Framework.

Board and Committee Structure
The Committee structure of the Board of Directors provides assurance on, and challenge to, the Trust's risk management process by managing and monitoring risk and providing assurance reporting to the Trust Board. Safety and risk is integral to all Board Committees. Each Board Committee is chaired by a Non-Executive Director to enhance independent scrutiny. Executive Directors provide leadership on the management of key areas of risk commensurate with their roles and are represented across the Board Committee structure.

The Board reviewed its response to oversight of important issues given national guidance on enhancing Board oversight and a new approach to Non-Executive Director champion roles issued in December 2021. The Board confirmed, at its meeting in March 2022, the five Non-Executive Director champion roles and the governance arrangements for Board Committees to provide oversight for the 13 roles which transition from individual Non-Executive Directors to the new approach. The terms of reference of the Quality Committee were revised to reflect the new responsibilities and respective reporting requirements arising from these changes.

The Board Committee structure discharging overall responsibilities for risk management and maintaining and reviewing the effectiveness of the system of internal control is summarised below:

- *Trust Board* has overall responsibility for risk management and having in place effective systems of risk management and internal control

- *Audit and Risk Committee, w*ith delegated authority from the Board, this Committee reviews the effectiveness of risk management and the system of internal control, governance and overall assurance processes across the whole of the Trust's activities that support delivery of the Trust's services and achievement of objectives. It has oversight of, and relies on, the work of the following:

    - Risk Group to monitor the risks reported on risk registers within divisions
    - Health and Safety Committee regarding assurance in relation to health and safety.
    - Information Governance and Records Strategy Group in relation to information governance
    - CQC and Compliance Group in relation to compliance
    - Data Quality Board for assurance on the quality of the performance information used by the Trust.

    This Committee also ensures effective internal and external audit.

- *Quality Committee* provides assurance to the Trust Board and Audit and Risk Committee, via the Quality Committee Chair, that adequate controls are in place to monitor the quality and safety of care for patients. This assurance focuses across all services and ensures that the quality governance structure is continuously monitoring and improving safe and effective patient care.

- *Finance and Performance Committee* scrutinises the financial risks and targets, and monitors any significant risks to activity and performance, with oversight of operational performance targets. The Committee is responsible for ensuring that there are robust financial performance reporting systems in place and receiving reports from the Joint Liaison Committee in line with the governance framework between the Trust and senior leadership of the Trust's wholly owned subsidiary CHS.

- *Workforce Committee* reviews workforce risks and provides assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management, recruitment, retention and health and wellbeing.

- *Transformation Programme Board* oversees the development and delivery of complex transformation programmes in the Trust (including hospital and community reconfiguration) and maintains a detailed risk register to ensure that the risks associated with the Transformation Programme are managed appropriately. It oversaw implementation and progress of the 12 “Business Better Than Usual” learning themes identified from new ways of working implemented during the pandemic. This Board also oversees the Trust’s Green Plan which provides a strategic framework for the Trust’s sustainability initiatives over the next five years.

  The above governance arrangements were in place throughout 2021/22. There was a more streamlined approach to Board and Board Committee meetings from January 2022 in line with NHS England / Improvement advice on Reducing the burden of reporting and releasing capacity to manage the Covid-19 pandemic due to the Omicron variant.

Board Assurance Framework (BAF)
The Trust Board is responsible for establishing the Trust’s strategic objectives. During the year reports were provided to the Board on progress with strategic objectives in support of delivery of the ten year strategy.

Effective systems are in place to identify and manage the risks associated with achieving these strategic objectives and a standing operating procedure for the BAF is in place. Risks to the Trust strategic objectives are owned by Directors, reviewed regularly and reported to the Board of Directors and the lead Board Committee via the Trust’s BAF, which provides the mechanism for the Trust Board to monitor risks, controls and the outputs of its assurance processes.

The Board, or identified responsible Board Committee, has oversight for each risk on the BAF. The spread of BAF risks by Committee is reviewed by Board Committee Chairs collectively to ensure that the risks are reviewed at the appropriate Committee, with any changes proposed taken to Board Committees for approval. Oversight of the BAF process is undertaken by the Audit and Risk Committee. The full BAF providing the organisation’s strategic risk profile was presented to the Board three times during the year. This provided a regular opportunity to review progress against mitigating actions and consider new or emerging risks.

The Trust’s risk appetite categories and descriptions were adjusted following discussion with key Executive Directors and approved by the Board in September 2021.

The Board Assurance Framework was independently reviewed by Internal Audit in March 2022 and an opinion of significant assurance was given.

Engagement with public stakeholders in risk management
The Trust engages public stakeholders in identifying and managing risks to its strategic objectives which may impact on them in a number of ways:

- as a Foundation Trust we aim to make best use of members and the Council of Governors. Through relevant groups we engage regularly with our governors on strategic, service and quality risks, including consulting them on the selection of the Trust’s quality priorities

- the public are involved in Trust activities with a range of communication and consultation mechanisms with relevant stakeholders
- the Trust is actively engaged in regional partnership working with health and social care services and ICS partners, regional acute providers via West Yorkshire Association of Acute Trusts and working relationships with Overview and Scrutiny Committees.

Workforce Strategies and Safeguards

The Trust has a Board of Directors' approved People Strategy that is consistent with the NHS People Plan and the associated People Promise. The strategy has served the Trust's approach to managing its people response to the pandemic well. Progress is monitored and reviewed by the Workforce Committee which is a main Board Committee. The strategy captures activities that delivers and supports sustainable, efficient and effective services including recruitment, retention, talent management, health and wellbeing and equality, diversity and inclusion.

The Workforce Committee provides assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management. Workforce risks are included in the Board Assurance Framework and the high-level risk register considered by the Board and the Workforce Committee regularly.

Workforce reports are submitted to the Board of Directors within the Integrated Performance Report which allow compliance and performance against the plan to be tracked. This is also reviewed and considered by the Workforce Committee.

The Workforce Committee receives the Nursing and Midwifery bi-annual Safer Staffing report before presentation to the Board of Directors. Presented by the Executive Director of Nursing the report provides an overview for nursing and midwifery staffing capacity and compliance in accordance with the National Institute for Excellence (NICE) Safe Staffing, National Quality Board (NQB) and the NHS Improvement Developing Workforce Safeguards guidance. The report provides assurance to the Board of the clear governance arrangements and oversight in place to ensure safe and sustainable staffing levels. In addition to the measures undertaken to address and respond to risk associated with the nursing and midwifery workforce, ensuring high quality compassionate care for patients across the Trust. The Board also receives specific nursing and midwifery safer staffing metrics including quality metrics.

Director led Performance Review Meetings with divisional management teams allow a focus on quality, activity, finance and workforce issues and ongoing testing of service plans.

The Board receives reports from the Trust's Guardian of Safe Working Hours and Freedom to Speak Up Guardian, the annual NHS staff survey and General Medical Council (GMC) doctors in training survey. The Board has a Non-Executive Director champion for staff health and well-being.

Workforce plans, using detailed clinical activity data, commissioning intentions and priorities and financial information, are created at PLACE level, Trust level and in specialty areas supported through annual planning events, further developed, critiqued, and prioritised at divisional level and after testing approved by Directors to form a Trust

wide workforce plan. An integrated quality, activity, finance, and workforce plan is signed-off by Directors and the Board of Directors.

The Trust has developed a workforce design methodology which provides a framework for reviewing services against principles including colleague 'must do's' relating to colleagues, patient safety and experience, digital, finance, and system and partner.

The Trust has implemented e-rostering systems for nursing and is progressing e-roster and e-job planning implementation for medical staff.

5. Compliance and validity of the NHS foundation trust condition 4 (FT Governance): Corporate Governance Statement

Although it remains unclear as to what the future licensing regime will be as a result of the government white paper relating to integrated care systems, the Trust remains technically in breach of its licence due to the underlying financial deficit and liaises regularly with NHS England/ NHS Improvement (NHS E/I).

On behalf of the Board of Directors the Audit and Risk Committee considers the validity of the Corporate Governance statement prior to submission to NHS E/I. All elements were confirmed when reviewed by the Audit and Risk Committee in April 2022 with no unmitigated risks to compliance identified. The assurance processes described in this statement allows the Board to issue an accurate Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b) of NHS England / NHS Improvement's provider licence.

The Trust believes that effective systems and processes are in place to maintain and monitor the following conditions:

- The effectiveness of governance structures
- The responsibilities of Directors and Board Committees
- Annual review of each Committee's effectiveness
- Reporting lines and accountabilities between the Board of Directors, its Committees and the Executive team
- The submission of timely and accurate information to assess risks to compliance with the Trust's licence
- The degree and rigour of oversight the Board of Directors and its Committees has over the Trust's performance

6. COMPLIANCE STATEMENTS

Care Quality Commission Compliance
The Trust is fully compliant with the registration requirements of the Care Quality Commission (CQC). Assurance on compliance with CQC requirements is achieved through the governance structure via a monthly CQC and Compliance Group and regular reports regarding CQC which are provided to the Quality Committee, Audit and Risk Committee (for compliance) and the Board.

A well-led inspection completed by the CQC in April 2018 focussed on the Trust's integrated governance and leadership across quality, finance, operations, organisational culture, improvement and systems working. These are consistent with the well-led framework from NHS England and NHS Improvement. The Trust received an improved overall rating of "good" by the CQC, with a "requires improvement" rating for Use of Resources. The Quality Committee oversees the Trust's progress with one ongoing action from the CQC well-led inspection report, with Use of Resources also reviewed by the Finance and Performance Committee. This Committee receives regular updates on the overall financial sustainability.

With regard to the NHS E/I well-led framework, the "good rating" from the well-led inspection and progression of remaining actions from the CQC inspection support the Trust in improving the governance of quality.

The pandemic has changed the way in which CQC regulates providers and there is no longer a set annual on-site inspection plan. Instead, the Trust has and continues to comply with CQC's revised approach to regulation in line with the development of their future strategy and ensures regular engagement with the CQC via the Relationship and Inspection Manager.

Well-led framework

The final stage of the well-led review, Board observation, commissioned from an external organisation based on NHS Improvement's well-led framework based on the Care Quality Commission's well-led key lines of enquiry, was completed by March 2021 (earlier phases included a self-assessment review and mapping review against the well-led domains). Further discussion on well-led governance took place at a Board development session workshop with the external organisation in June 2021, where the Board considered Trust priorities within the well-led framework.

The Trust is not required to commission a further independent well-led review until 2024.

During 2021/22 the Trust has undertaken the following to support a well-led approach to deliver high quality, sustainable care:

- With regards to leadership capacity and capability, Board development sessions were held during 2021/22 based on the CQC key domains. A Trust wide leadership development programme was put in place with visible leadership presence by Executive Directors, including enhanced leadership involvement in on site on call. Non-Executive Directors attended a wide range of engagement forums across the Trust and two participate in a patient experience assessment tool (virtual Observe and Act assessment). There are plans for further Board development during 2022/23 with external well-led specialists in place

- In terms of a clear vision and credible strategy, robust arrangements have remained in place to assess and report to Board on progress and activity in terms of strategic objectives, partnership working, progressing ambitions around becoming an anchor institution, progression of reconfiguration plans, and support from the Social Value Portal in measuring and quantifying social value in terms of economic, social and environmental impact of the Trust's planned estate investment at its two hospital sites, ensuring the investment secures wider

social benefits that are targeted to reduce health inequalities experienced by our local communities

- In terms of culture, leadership briefings are undertaken three times a week with a Chief Executive live briefing weekly where staff can submit questions. We have increased the number of Freedom to Speak Up Guardians, strengthened our staff well-being offer (access to health and well-being hours, risk assessments and psychological support), re-introduced Schwarz rounds, maintained our processes for patient safety and quality governance and had in place a timetable of quality assessment visits to provide assurance from wards to the Board

- To ensure clear responsibilities, roles and systems of accountability to support good governance and management annual reviews of Committee effectiveness have been undertaken, with assurance reported to the Board. Quality priorities have been reviewed and refreshed, with engagement with our Council of Governors and our divisional Patient Safety Quality Boards who report to the Trust Quality Committee

- To support clear and effective processes for managing risks, issues and performance, the Performance Accountability Framework was reviewed and agreed at Board with performance review meetings in place with clinical divisions, risk registers have been updated and undergone full review at Trust level, and there have been strengthened escalation processes to match demand, mapped to OPEL levels

- To ensure appropriate and accurate information is being effectively processed, challenged and acted on the integrated performance report has been strengthened to allow for improved triangulation and our bespoke business intelligence system, Knowledge Portal, has been rolled out to a wider range of colleagues

- Engagement and involvement with people who use services, the public, staff and external partners has included sharing patient stories at Board meetings. Service users with learning disabilities have been prioritised as part of the waiting list back log plans and engagement has taken place with a range of external stakeholders on our Trust reconfiguration plans

- We continue to learn, improve and innovate, with our Trust research team having been national leaders in terms of Covid research and the Getting It Right First Time (GIRFT) programme. We have launched a care of the acutely ill patient programme and have worked with colleagues to make service improvements using our Trust improvement methodology, Working Together to Get Results

Register of Interests Compliance

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. This can be accessed at the following address: https://cht.mydeclarations.co.uk/declarations

Compliance with NHS pension scheme regulations

As an employer with staff entitled to membership of the NHS Pension Scheme and the NEST Pension Scheme, control measures are in place to ensure all employer

obligations contained within each of the scheme's regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the schemes 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.

Trust Impact on the environment
CHFT has undertaken risk assessments and has plans in place which take account of the "Delivering a Net Zero Health Service" report under the Greener NHS programme. CHFT has a Board approved Green Plan supported by a detailed action plan. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Further information on environmental matters, including the impact of the Trust's business on the environment, can be found in the performance analysis section of the performance report within the annual report.

7. Quality Governance Arrangements

The key elements of the Trust's quality governance are described below.

The Quality Committee is responsible for providing the Board with assurance on all aspects of the quality of clinical care, patient experience, clinical governance systems, clinical audit and standards of quality and safety. The Quality Committee structures its workplan around the CQC domains. It is a formal Committee of the Board and chaired by a Non-Executive Director and reports to the Board of Directors. The chair of the Quality Committee attends meetings of the Audit and Risk Committee to strengthen the links between these two Board Committees.

The Quality Committee scrutinises the quality information within the monthly Board performance report, clinical risks within the Board Assurance Framework and any quality related internal audit reports with limited assurance.

The Quality Committee receives reports from specialist governance groups such as the Safeguarding Committee, Clinical Outcomes Group and Patient and Safety Quality Boards seeking assurance from clinical divisions about the governance of the quality of their services.

The Quality Strategy has a clear quality governance reporting structure approved by the Quality Committee and the Board. During the year a detailed Quality report has been presented to each Board meeting which has provided ongoing oversight of the quality agenda and demonstrated that the processes and systems within the Trust to ensure quality and safety are fit for purpose. The report has included assurance on key quality and patient experience outcomes and identified any emerging issues for consideration by the Board.

8. Data Quality and Governance: Data driven performance framework

The Trust has in place policies to assure the Board on a range of issues to ensure high quality compassionate care is provided to patients. Systems and processes are in place to assure data accuracy and validity into the Board ensuring there is robust ward to Board assurance on the quality of care we deliver. Policies and standard operating procedures to this effect are reviewed on a regular basis.

Assessment of the quality of performance information
Assurance that the performance data used within the Trust is of a high standard is the responsibility of the Trust Data Quality Board, which met every six weeks and reported to the Audit and Risk Committee with escalation into a weekly meeting of Executive Directors as appropriate. A Data Quality Group, which meets every six weeks and reports into the Data Quality Board, focuses on specific data quality measures from both a corporate and service position.

There is a Data Quality Policy that relates to all areas of data quality, including the Electronic Patient Record. It relates to all data produced by the Foundation Trust.

High quality data is a fundamental requirement for the Trust to conduct its business efficiently and effectively. It enables the delivery of the Trust's four pillars and is central to the Trust's on-going ability to meets its statutory, legal, financial and other contractual requirements.

With regard to elective waiting time data, the Trust is one of the 12 field sites selected in the summer of 2019 for the Elective Care Clinical Review of Standards and reports against the new measure which is an average wait standard. The field testing was suspended during the Covid-19 pandemic and will be reintroduced during 2022/23.

The Board reviews the quality of performance information via a comprehensive Integrated Performance Report (IPR). Assurance data within the IPR is reviewed monthly by the Executive team and Board Committees with detailed scrutiny each month by the Finance and Performance and Quality Committees. The monthly IPR uses a range of metrics that allows the triangulation of performance data for wider assurance including external benchmarking and trend analysis. The Data Quality Board oversees deep dives on Key Performance Indicators (KPIs). The IPR includes narrative on areas of concern with associated recovery actions and timelines.

The Trust reviewed its Performance Management and Accountability Framework at the end of 2020/21 and introduced recommendations from April 2021, with ongoing review during the year. The refreshed framework included an update to the Integrated Performance Report and reference to data quality alongside the development of a single combined narrative that now includes narrative that further triangulates performance for greater Board assurance.

The IPR now includes renewed focus on:

- Covid-19 stabilisation and recovery
- Prioritisation of work to reduce health inequalities
- Outcome based indicators
- Quality priorities

- Triangulation between quality, workforce and finance

In addition to the IPR report, the Board receives a regular comprehensive quality and safety report which provides a detailed oversight of performance against nationally and locally agreed improvement requirements. This report has been integrated into the IPR via the inclusion of quality priority metrics.

Programme of Deep-Dives
The Trust has continued its formal programme of deep dives across the key performance indicators (KPIs) within the Integrated Performance Report (IPR) which provide the Board with assurance on KPIs that regularly achieve target (Green RAG rating) and an understanding of the challenges of those that are currently missing their target (Red RAG rating) with a focus on improvement. Formal reporting is via the Data Quality Board and Quality and Performance Executive Board on a monthly basis with a programme established for the next 12 months.

The Trust has a comprehensive programme of “Getting It Right First Time” (GIRFT) which improves quality of care by bringing efficiencies and improvements. The GIRFT programme provides independent clinical assessment, challenge and benchmarking that drives quality and performance improvement. The Trust has been recognised as a national exemplar for this work. The GIRFT programme is now managed through the bi-monthly divisional Performance Review meetings.

Performance Review Meetings
Divisional Performance Review meetings, suspended during the 2020/21 Covid19 pandemic, recommenced from April 2021 in a streamlined way with revised terms of reference as described in the updated Performance and Accountability Framework. These meetings continued throughout the ongoing operational Covid-19 pressures during 2021/22. These are the single point for all performance related discussions with Divisions, allowing for the triangulation of the various domains and ensuring the interdependencies of decisions are identified. They combine performance management with performance support and the agendas are jointly developed by the Directors and the Divisional teams. The Chief Operating Officer is responsible for organising and leading the review meetings alongside the Executive Directors of the Board.

9. Financial Governance

The Trust is operating in an evolving financial environment with increased expectations of financial connectivity across the local Kirklees and Calderdale PLACEs and across the Integrated Care System. This overlays the challenges presented by Covid-19, elective recovery requirements and continued business as usual pressures.

The Trust continues to be technically under enforcement action from its regulator NHSE/I following the breach of licence with an unplanned deficit in 2014/15. This breach of licence resulted in a number of actions which have been formally acknowledged as completed, with the exception of the undertaking to 'ensure the Licensee’s clinical and financial stability is maintained from the end of the financial year 2016/2017’ which is still largely connected to the successful implementation of the reconfiguration of hospital and community services.

In 2021/22, as in previous years since the breach of licence was enacted, the Trust has successfully delivered a year-end financial position in line with the plans submitted to the regulator. In year performance against revenue and capital plans is monitored through the Trust's Finance and Performance Committee and reported to both the Integrated Care System and NHSE/I on a monthly basis. The Finance and Performance Committee also oversees the position against the Use of Resources expectations, whilst the Audit and Risk Committee oversees financial governance arrangements.

In December 2018 the Department of Health and Social Care confirmed allocation of £197m public dividend capital to progress the reconfiguration. The Strategic Outline Case for Reconfiguration was approved at national level by NHS England / NHS Improvement Delivery and Quality Performance Committee in November 2019. The Trust is now working to develop the required Full Business Case that will enable the reconfiguration to be completed by 2026, and transformational efficiencies to be delivered thereafter subject to the relevant approvals. The development and implementation of these plans is monitored through the Trust's Transformation Programme Board.

10. Information Governance

The reporting and management of both data and security risks are supported by ensuring that all employees of the Trust are reminded of their data security responsibilities through education and awareness. Over 90% of staff members completed updated information governance staff training in 2021/22. Regular reminders and lessons learned are shared through staff communications, including where identified as a requirement following local incident reviews and risk assessments.

In addition to mandatory staff training, a range of measures is used to manage and mitigate information risks, including, physical security, data encryption, access controls, audit trail monitoring, departmental checklists and spot checks. In addition, a comprehensive assessment of information security is taken annually as part of the Data Security and Protection Toolkit (DSPT) and further assurance is provided from internal audit and other reviews. The effectiveness of these measures is reported to the Information Governance and Records Strategy Committee. This includes details of any personal data-related Serious Incidents, the Trust's annual DSPT compliance and reports of other information governance incidents and audit reviews.

All Trust laptops and USB data sticks issued to and used by staff are encrypted to protect the Trust IT systems from malware and cyber-attack. A password policy has been developed and implemented which introduced stronger controls around the complexity and frequency of change of passwords, which conforms to national recommended standards.

Robust information governance is extremely important to the Trust. The Trust uses NHS Digital's DSPT 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.

In accordance with the Information Asset Identification Project, a centralised major information asset register has been updated and fully supports the role of the Trust's

Information Asset Owners who report to the Senior Information Risk Owner (SIRO). Any concerns identified through the registration and management of the Information Assets will be pursued through the recognised and accepted managerial line. Failure to deal with a concern through that route will be taken up by the SIRO with the appropriate Information Asset Owner within the Trust.

The Trust's 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 DSPT, and, where appropriate, recorded on the Corporate Risk Register. Detailed scrutiny of Information Governance risks is undertaken through the Information Governance and Records Strategy Committee Group, which reports to the Audit and Risk Committee. The Risk Group and the Health Informatics Executive Board 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 Trust's Data Protection Officer (DPO) is the point of contact for the public and Information Commissioner's Office (ICO). The DPO is in place to inform the organisation and its employees of their obligations under the data protection regime and monitors compliance with the law, including conducting audits and advising on data protection impact assessments.

The Chief Executive has overall responsibility for all aspects of information management, including security and governance, and is accountable to the Board of Directors. All Board members received training on cyber security during the year.

The organisation is continuing with significant areas of work to ensure that systems and processes are in place to meet the UK General Data Protection Regulation (GDPR) requirements as well as communicating what it means for staff and patients. The organisation has significant assurance regarding compliance to the regulations.

There have been three Information Commissioner's Officer (ICO) reportable incidents in the last 12 months reported in April and November 2021. These related to the inappropriate sharing of personal data and inappropriate storage of data. The incidents have been closed by the ICO with no further action required. The Trust has implemented mitigation/lessons learned which include a local working document on the safe transfer and storage of personal data, a review of methods of communicating personal data within and outside of the Trust, using secure digital processes where possible to minimise risk, with strengthened controls for personal data being shared outside of the organisation.

11. 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;
- Developed and monitored detailed plans reflecting service and operational requirements and financial plans with monitoring of organisational performance;
- Ensured that Scheme of Reservation and Delegation of Powers and Standing Financial Instructions are in place and reviewed so that the Trust's transactions are carried out in accordance with the law, government policy and good practice in order to achieve probity, accuracy, economy, efficiency and effectiveness; and
- Developed engagement processes with patients, staff, members, governors and other stakeholders to ensure key messages about services are received and acted upon.

Auditors
The Trust makes use of internal auditors and external auditors to support governance arrangements, deliver economic, efficient and effective use of resources and ensure that controls are effective. During the year the Trust undertook a procurement process, involving and approved by governors, for the appointment of external auditors, with KPMG re-appointed as external auditor. Assurances on the operation of controls are reviewed by the Audit and Risk Committee and, where appropriate, the Committees of the Board of Directors as part of their annual cycle of business.

Internal Audit work was commissioned to review the adequacy of controls and assurances in place via a comprehensive audit programme agreed on behalf of the Board by the Audit and Risk Committee. The ability to complete all planned audits was affected by the Covid-19 pandemic and a number of audits were cancelled following discussion with relevant Directors, with a consequent reduction in planned audit days.

There were a total of 31 finalised reports issued during 2021/22 with:

- 7 high assurance opinions
- 21 significant assurance opinions
- 1 limited assurance opinion
- 2 no opinion

One internal audit report received a limited assurance opinion regarding pharmaceutical waste in clinical areas. All reports where an opinion is provided have recommendations, with an action plan in place to address these recommendations and a target date set until all actions are completed.

The work of the internal auditors, including monitoring of progress with recommendations, is reviewed by the relevant Committee and the Audit and Risk Committee.

External auditors carry out the audit of financial systems and comment specifically on the use of resources and going concern in their reports for the Audit and Risk Committee. External auditors provide independent assurance on the accounts, annual report and Annual Governance Statement.

Role of the Board
The Board has a key role in ensuring that resources are used economically, efficiently and effectively. For 2021/22 the Trust produced operational plans and supporting

detailed financial plans for the year split into two tranches Half 1, April to September and Half 2, October to March in line with national requirements. The Board has received regular reports outlining the year to date and forecast financial performance against these plans. Draft 2022/23 plans were received and approved by the Board in March 2022 with the final plans to be submitted to regulators in April 2022.

These documents, together with internal audits of specific areas of internal control and the external audit, 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.

The resources of the Trust are managed through various measures, including a governance structure at Executive Management level and below, divisional performance review meetings, a robust budgetary control system and the consistent application of internal financial controls and effective procurement and tendering procedures. All budget holders are required to undertake regular finance training to support them to 'manage our money'. In 2020/21 specific financial governance arrangements were approved and put in place to support expedient but legal decision making to deal with the pandemic situation. These special temporary arrangements were stood down during 2021/22 with the approval of Audit and Risk Committee.

12. 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, clinical audit and the executive managers and clinical leads within the NHS Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letters 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, the Audit and Risk Committee, the Finance and Performance Committee and the Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place. The role of Board Committees is detailed in the Board and Committee Structure section of this statement.

In accordance with NHS internal audit standards, the Head of Internal Audit provides me with an overall annual opinion statement to the Trust, based upon and limited to the work performed, on the assurance framework and overall adequacy and effectiveness of the Trust's risk management, control and governance processes. The Trust received a significant assurance opinion on the Trust's system of internal control from internal auditors, which I have taken into account when making this Annual Governance Statement.

13. Conclusion

This Annual Governance Statement requires me to consider whether there are any significant internal control issues facing the Trust. Risks regarding the impact of the Covid-19 pandemic and challenges regarding the recovery of activity are identified above.

I am assured that Calderdale and Huddersfield NHS Foundation Trust has an overall sound system of internal controls in place and that no significant internal control issues have been identified.

Professor Brendan Brown
Chief Executive

5 July 2022

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Calderdale and Huddersfield NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Group and Trust Statement of Comprehensive Income, Group and Trust Statement of Financial Position, Group and Trust Statement of Changes in Taxpayers Equity and Group and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

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

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Risk Committee and inspection of policy documentation as to the Group's high-level policies and procedures to prevent and detect fraud, including the internal audit counter-fraud function, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve control totals delegated to the Group by NHS Improvement.
- Reading Board and Audit and Risk Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk that management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted in relation to significant estimates, journals posted by finance executives and unusual cash and expenditure journals.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Sample testing expenditure transactions around the period end (including accruals), vouching to supporting documentation to corroborate whether those items were recorded in the correct accounting period and calculated correctly.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards) and discussed with the directors the policies and procedures regarding compliance with laws and regulations.

As the Group is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Group is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Group is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information.
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion that report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 140, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Group and Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Group and Trust without the transfer of their services to another public sector entity.

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

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

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

Under Section 62(1) and paragraph 1(d) of Schedule 10 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

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

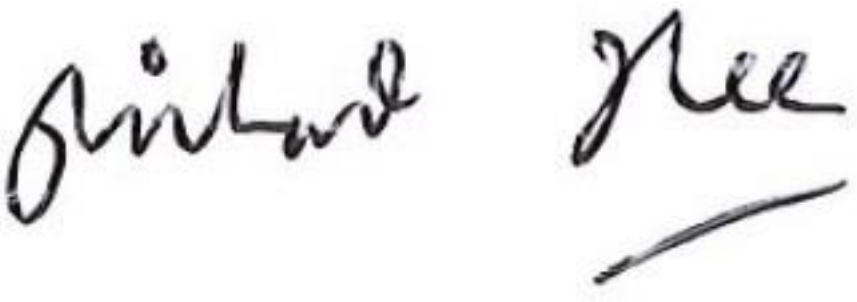
We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts Calderdale and Huddersfield NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Richard Lee
for and on behalf of KPMG LLP
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

8 July 2022

4. Annual Accounts 2021/22

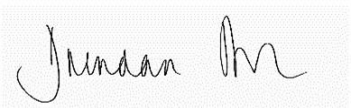
Calderdale & Huddersfield NHS Foundation Trust

Annual accounts for the year ended 31 March 2022

Foreword to the accounts

Calderdale & Huddersfield NHS Foundation Trust

These accounts, for the year ended 31 March 2022, have been prepared by Calderdale & Huddersfield NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed  ……

Name Professor Brendan Brown
Job title Chief Executive
Date 5 July 2022

Statement of Comprehensive Income

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Operating income from patient care activities	3	463,976	401,083	463,261	400,499
Other operating income	4	56,200	90,132	58,160	90,201
Operating expenses	6, 8	(506,449)	(488,068)	(507,509)	(487,006)
Operating surplus/(deficit) from continuing operations		**13,727**	**3,147**	**13,912**	**3,694**
Finance income	11	84	41	3,423	3,604
Finance expenses	12	(12,950)	(12,221)	(16,935)	(16,512)
PDC dividends payable		(1,272)	(636)	(1,272)	(636)
Net finance costs		**(14,138)**	**(12,817)**	**(14,784)**	**(13,543)**
Other gains / (losses)	13	(108)	298	(108)	298
Share of profit / (losses) of associates / joint arrangements	21	265	-	265	-
Gains / (losses) arising from transfers by absorption	43	-	-	-	-
Corporation tax expense		(48)	(27)	-	-
Surplus / (deficit) for the year from continuing operations		**(301)**	**(9,399)**	**(715)**	**(9,551)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-	-	-
Surplus / (deficit) for the year*		**(301)**	**(9,399)**	**(715)**	**(9,551)**
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Impairments	7	1,095	(2,192)	1,095	(2,192)
Revaluations	20	-	-	-	-
Share of comprehensive income from associates and joint ventures	21	-	-	-	-
Fair value gains / (losses) on equity instruments designated at fair value through OCI	22	-	-	-	-
Other recognised gains and losses		-	-	-	-
Gain / (loss) arising from on transfers by modified absorption	43	-	-	-	-
Other reserve movements		-	-	-	-
May be reclassified to income and expenditure when certain conditions are met:					
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	13	-	-	-	-
Foreign exchange gains / (losses) recognised directly in OCI		-	-	-	-
Total comprehensive income / (expense) for the period		**793**	**(11,591)**	**380**	**(11,743)**
Surplus/ (deficit) for the period attributable to:					
Non-controlling interest, and					
Calderdale and Huddersfield NHS Foundation Trust		(301)	(9,399)	(715)	(9,551)
TOTAL		**(301)**	**(9,399)**	**(715)**	**(9,551)**
Total comprehensive income/ (expense) for the period attributable to:					
Non-controlling interest, and					
Calderdale & Huddersfield NHS Foundation Trust		793	(11,591)	380	(11,743)
TOTAL		**793**	**(11,591)**	**380**	**(11,743)**

* The surplus / (deficit) for 2021/22 includes £0.318m of impairments; for 2020/2021 this was £12.920m of impairments.

Statement of Financial Position

	Note	Group 31 March 2022 £000	Group 31 March 2021 £000	Trust 31 March 2022 £000	Trust 31 March 2021 £000
Non-current assets					
Intangible assets	15	5,899	8,156	5,899	8,156
Property, plant and equipment	17	177,296	163,503	176,818	163,049
Investment property	21	-	-	-	-
Investments in associates and joint ventures	21	4,177	3,912	4,177	3,912
Other investments / financial assets	22	-	-	527	1,553
Receivables	25	4,515	3,908	59,466	62,692
Other assets	26	-	-	-	-
Total non-current assets		**191,887**	**179,479**	**246,887**	**239,362**
Current assets					
Inventories	24	7,612	7,458	5,460	5,430
Receivables	25	22,762	20,731	26,266	25,727
Other investments / financial assets	22	4,000	4,000	5,030	4,997
Other assets	26	-	-	-	-
Non-current assets for sale and assets in disposal groups	27.1	275	275	275	275
Cash and cash equivalents	28	54,744	48,222	52,422	46,958
Total current assets		**89,393**	**80,686**	**89,453**	**83,387**
Current liabilities					
Trade and other payables	29	(76,748)	(63,731)	(72,039)	(61,685)
Borrowings	31	(5,851)	(5,410)	(17,940)	(9,858)
Other financial liabilities	32	-	-	-	-
Provisions	34	(7,487)	(6,426)	(7,487)	(6,426)
Other liabilities	30	(7,450)	(4,682)	(7,450)	(4,682)
Liabilities in disposal groups	27.2	-	-	-	-
Total current liabilities		**(97,535)**	**(80,249)**	**(104,916)**	**(82,651)**
Total assets less current liabilities		**183,745**	**179,917**	**231,424**	**240,098**
Non-current liabilities					
Trade and other payables	29	(107)	(97)	(107)	(97)
Borrowings	31	(79,848)	(85,548)	(128,697)	(146,485)
Other financial liabilities	32	-	-	-	-
Provisions	34	(1,158)	(1,185)	(1,158)	(1,185)
Other liabilities	30	(785)	(893)	(785)	(893)
Total non-current liabilities		**(81,897)**	**(87,723)**	**(130,746)**	**(148,661)**
Total assets employed		**101,848**	**92,194**	**100,678**	**91,437**
Financed by					
Public dividend capital		289,865	281,004	289,865	281,004
Revaluation reserve		3,761	2,724	3,761	2,724
Financial assets reserve		-	-	-	-
Other reserves		-	-	-	-
Merger reserve		-	-	-	-
Income and expenditure reserve		(191,778)	(191,534)	(192,949)	(192,291)
Total taxpayers' equity		**101,848**	**92,194**	**100,678**	**91,437**

The notes 1 -42 on the following pages form part of these accounts

Name Professor Brendan Brown
Position Chief Executive
Date 5 July 2022

Statement of Changes in Equity for the year ended 31 March 2022

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**281,004**	**2,724**	**(191,534)**	**92,194**
Surplus/(deficit) for the year	-	-	(301)	**(301)**
Other transfers between reserves	-	(57)	57	**-**
Impairments	-	1,095	-	**1,095**
Public dividend capital received	8,861	-	-	**8,861**
Taxpayers' and others' equity at 31 March 2022	**289,865**	**3,761**	**(191,778)**	**101,848**

Statement of Changes in Equity for the year ended 31 March 2021

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**122,410**	**5,321**	**(182,540)**	**(54,809)**
Surplus/(deficit) for the year	-	-	(9,399)	**(9,399)**
Other transfers between reserves	-	(165)	165	**-**
Impairments	-	(2,192)	-	**(2,192)**
Transfer to retained earnings on disposal of assets	-	(240)	240	**-**
Public dividend capital received	158,594	-	-	**158,594**
Taxpayers' and others' equity at 31 March 2021	**281,004**	**2,724**	**(191,534)**	**92,194**

Statement of Changes in Equity for the year ended 31 March 2022

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2021 - brought forward	**281,004**	**2,724**	**(192,291)**	**91,437**
Surplus/(deficit) for the year	-	-	(715)	**(715)**
Other transfers between reserves	-	(57)	57	**-**
Impairments	-	1,095	-	**1,095**
Public dividend capital received	8,861	-	-	**8,861**
Public dividend capital repaid	-	-	-	**-**
Public dividend capital written off	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	**-**
Other reserve movements	-	-	-	**-**
Taxpayers' and others' equity at 31 March 2022	**289,865**	**3,761**	**(192,949)**	**100,678**

Statement of Changes in Equity for the year ended 31 March 2021

Trust	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2020 - brought forward	**122,410**	**5,321**	**(183,145)**	**(55,414)**
Surplus/(deficit) for the year	-	-	(9,551)	**(9,551)**
Other transfers between reserves	-	(165)	165	**-**
Impairments	-	(2,192)	-	**(2,192)**
Transfer to retained earnings on disposal of assets	-	(240)	240	**-**
Public dividend capital received	158,594	-	-	**158,594**
Taxpayers' and others' equity at 31 March 2021	**281,004**	**2,724**	**(192,291)**	**91,437**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Financial assets reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of Cash Flows

		Group		Trust	
		2021/22	2020/21	2021/22	2020/21
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		13,727	3,147	13,912	3,694
Non-cash income and expense:					
Depreciation and amortisation	6.1	13,492	11,007	13,405	10,952
Net impairments	7	318	12,920	318	12,920
Income recognised in respect of capital donations	4	(927)	(2,463)	(927)	(2,463)
Amortisation of PFI deferred credit		-	-	-	-
Non-cash movements in on-SoFP pension liability		-	-	-	-
(Increase) / decrease in receivables and other assets		(2,874)	20,973	2,451	25,890
(Increase) / decrease in inventories		(154)	(949)	(30)	(598)
Increase / (decrease) in payables and other liabilities		11,642	9,721	8,980	7,993
Increase / (decrease) in provisions		1,033	3,579	1,033	3,579
Tax (paid) / received		(48)	(27)	-	-
Operating cash flows from discontinued operations		-	-	-	-
Other movements in operating cash flows		(2)	-	4	3
Net cash flows from / (used in) operating activities		**36,207**	**57,907**	**39,146**	**61,971**
Cash flows from investing activities					
Interest received		84	41	3,423	3,607
Purchase and sale of financial assets / investments		-	-	990	956
Purchase of intangible assets		(615)	(863)	(615)	(863)
Sales of intangible assets		-	-	-	-
Purchase of PPE and investment property		(19,048)	(19,008)	(18,939)	(18,788)
Sales of PPE and investment property		7	1,144	7	1,144
Receipt of cash donations to purchase assets		269	59	269	59
Prepayment of PFI capital contributions		-	-	-	-
Investing cash flows from discontinued operations		-	-	-	-
Cash from acquisitions / disposals of subsidiaries		-	-	-	-
Net cash flows from / (used in) investing activities		**(19,303)**	**(18,627)**	**(14,865)**	**(13,886)**
Cash flows from financing activities					
Public dividend capital received		8,861	158,594	8,861	158,594
Public dividend capital repaid		-	-	-	-
Movement on loans from DHSC		(2,208)	(142,926)	(2,208)	(142,926)
Movement on other loans		-	-	-	-
Other capital receipts		-	-	-	-
Capital element of finance lease rental payments		(8)	(8)	(4,458)	(4,153)
Capital element of PFI, LIFT and other service concession payments		(3,022)	(1,833)	(3,022)	(1,833)
Interest on loans		(454)	(1,115)	(454)	(1,115)
Other interest		(0)	(1)	(0)	(1)
Interest paid on finance lease liabilities		-	-	(3,985)	(4,290)
Interest paid on PFI, LIFT and other service concession obligations		(12,515)	(11,732)	(12,515)	(11,732)
PDC dividend (paid) / refunded		(1,036)	(1,325)	(1,036)	(1,325)
Financing cash flows of discontinued operations		-	-	-	-
Cash flows from (used in) other financing activities		-	-	-	-
Net cash flows from / (used in) financing activities		**(10,382)**	**(346)**	**(18,817)**	**(8,781)**
Increase / (decrease) in cash and cash equivalents		**6,522**	**38,934**	**5,464**	**39,304**
Cash and cash equivalents at 1 April - brought forward		**48,222**	**9,289**	**46,958**	**7,655**
Prior period adjustments			-		-
Cash and cash equivalents at 1 April - restated		**48,222**	**9,289**	**46,958**	**7,655**
Cash and cash equivalents transferred under absorption accounting	43	-	-	-	-
Unrealised gains / (losses) on foreign exchange		-	-	-	-
Cash and cash equivalents at 31 March	28.1	**54,744**	**48,222**	**52,422**	**46,958**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to 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.

Note 1.2 Going concern

The accounting concept of Going Concern refers to the basis on which an organisation's assets and liabilities are recorded and included in the accounts. If an organisation is a going concern, it is expected to operate and not go out of business or liquidate its assets in the foreseeable future.
For non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is evidence of going concern.
The Trust Board has assessed whether it is appropriate to prepare the accounts on a going concern basis in this context.
The following has been taken into account:
- The ongoing requirement for health services, such as those provided by the Trust, is set out in legislation including the Health Act and Health and Social Care Act
- The West Yorkshire Integrated Care System long-term plans incorporate the continued provision of the services provided by the Trust.
- The Trust has its own long-term plans, as outlined in the business case for reconfiguration of services which have the support of NHS England / NHS Improvement (NHS E/I).

Based on these indications the Directors believe that it remains appropriate to prepare the accounts on a going concern basis.

Note 1.3 Interests in other entities

NHS Charitable Funds
The Trust is the corporate Trustee to Calderdale and Huddersfield Foundation Trust NHS Charitable Fund. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the 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 Trust has assessed that the values involved are not of a material nature and the Board of Directors has approved and agreed not to consolidate the charitable funds.

Other subsidiaries

The Trust has a wholly owned subsidiary company, Calderdale and Huddersfield Solutions (CHS) Ltd. The function of the company is to provide a managed health care facility to the Trust.

CHS Ltd. commenced trading on 1 September 2018. The year end for the company is 31 March to align with the Trust.

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.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at a Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and, in 2020/21, other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

As per paragraph 121 of the Standard the Trust does not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less. The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date. The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Other Income
Other income for non patient care services is accounted for in the period in which the specific service is delivered. Where income is received for an activity 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 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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.

Other Pension costs
The Foundation Trust Group offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST) for those staff ineligible to contribute to the NHS Pension.

The cost to the Foundation Trust of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Note 1.7 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 1.8 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are ‘machinery of government changes’ and treated as continuing operations.

Note 1.9 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 lives.

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.

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.

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Valuation guidance issued by the Royal Institute of Chartered Surveyors states that valuations are performed net of VAT where the VAT is recoverable by the entity. This basis has been applied to the trust's Private Finance Initiative (PFI) at Calderdale Royal Hospital scheme where the construction is completed by a special purpose vehicle and the costs have recoverable VAT for the trust and also for the Huddersfield Royal Infirmary site as any construction would be completed by Calderdale and Huddersfield Solutions under a managed service contract making the cost also recoverable for VAT.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.
A full on-site valuation was carried out as at 1st April 2018. A desktop interim revaluation was undertaken as at 31 March 2022. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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’ cease 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 expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

This includes assets donated to the trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the trust applies the principle of donated asset accounting to assets that the trust controls and is obtaining economic benefits from at the year end.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) 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 HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	12	78
Dwellings	-	-
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 life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.10 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 where it meets the requirements set out in IAS 38.

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 where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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 lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	**Max life Years**
Information technology	5	5
Development expenditure	-	-
Websites	-	-
Software licences	5	5
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.11 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 a fair value due to the high turnover of stock.

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by using the aging of debt as a means of determining the likelihood of receipt of payment. All Non NHS receivables over 90 days are provided in full and specific high risk debt categories over 30 days are provided in full. Debt in relation to other NHS bodies is not recognised in expected credit losses.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as a lessee

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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 charge 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.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The trust as a lessor

Finance leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Operating leases

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 34.2 but is not recognised in the Trust’s accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 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 35 where an inflow of economic benefits is probable.
Contingent liabilities are not recognised, but are disclosed in note 35, 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 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.19 Corporation tax
Calderdale and Huddersfield Solutions Ltd, is a wholly owned subsidiary of Calderdale and Huddersfield NHS Foundation Trust and is subject to corporation tax on its profits.

Note 1.20 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.21 Foreign exchange

The functional and presentational currency of the trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

• monetary items 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 1.22 Third party assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM* .

Note 1.23 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.

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 1.24 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 statement of financial position	
Additional right of use assets recognised for existing operating leases	22,344
Additional lease obligations recognised for existing operating leases	(20,928)
Changes to other statement of financial position line items	(1,416)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(2,975)
Additional finance costs on lease liabilities	(216)
Lease rentals no longer charged to operating expenditure	2,910
Other impact on income / expenditure	-
Estimated impact on surplus / deficit in 2022/23	**(281)**
Estimated increase in capital additions for new leases commencing in 2022/23	**3,116**

From 1 April 2022, the principles of IFRS 16 will also be applied to the Trust's PFI liabilities where future payments are linked to a price index representing the rate of inflation. The PFI liability will be remeasured when a change in the index causes a change in future repayments and that change has taken effect in the cash flow. Under existing accounting practices, amounts relating to changes in the price index are expensed as incurred. This is expected to increase the PFI liability on the statement of financial position upon transition to IFRS 16. The effect of this has not yet been quantified.

Other standards, amendments and interpretations

As required by IAS 8, the Trust declares the following other standards, amendments and interpretations have been issued but are not yet effective or adopted for the public sector. IFRS 14: Applies to first time adoptors of IFRS after 1 January 2016, therefore not applicable to the Trust. IFRS17 Insurance Contracts: Application required for accounting periods beginning on or after 1 January 2023 but not yet adopted by the FReM, early adoption is not therefore permitted.

Note 1.27 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

The preparation of the financial information , in conformity with IFRS, requires management to make judgements, estimates and assumptions that affect the application of policies and the reported amounts of income and expenses and of assets and liabilities. The estimates and assumptions are based on historical experience and other factors that are believed to be reasonable under all the circumstances. Actual results may vary from these estimates. The estimates and assumptions are reviewed on an on-going bases. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision only affects that period, or in the period of the revision of future periods, if the revision affects both the current and future periods.

Note 1.28 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 17.1
The revaluation of the hospital has been carried out by Cushman Wakefield, who have applied the modern equivalent asset valuation. This approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design. The modern equivalent may well be smaller than the existing asset, for example due to technological advances in plant and machinery or reduced operational use.

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 Foundation 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 levels of activity are agreed with our main commissioners for the year, and are listed in the related party disclosures (see Note 42).

Healthcare

The large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore a segment of 'Healthcare' is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board. The Trust Board reviews the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a distinct operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers this segment of healthcare in its decision-making process.

	Group Healthcare	
	2021/22 £000	**2020/21 £000**
Income	**520,177**	**491,215**
Surplus / (Deficit)	**(301)**	**(9,399)**
Net Assets (Liabilities)	**101,848**	**92,194**

	Trust Healthcare	
	2021/22 £000	**2020/21 £000**
Income	**521,421**	**490,700**
Surplus / (Deficit)	**(715)**	**(9,551)**
Net Assets (Liabilities)	**100,678**	**91,437**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

	Group		Trust	
		Restated		Restated
Note 3.1 Income from patient care activities (by nature)	**2021/22**	**2020/21**	**2021/22**	**2020/21**
	£000	**£000**	**£000**	**£000**
Acute services				
Block contract / system envelope income	410,470	322,813	410,470	322,813
High cost drugs income from commissioners (excluding pass-through costs)	-	25,477	-	25,477
Other NHS clinical income *	3,830	980	3,734	975
Mental health services				
Block contract / system envelope income	-	-	-	-
Services delivered under a mental health collaborative	-	-	-	-
Income for commissioning services in a mental health collaborative	-	-	-	-
Clinical partnerships providing mandatory services (including S75 agreements)	-	-	-	-
Clinical income for the secondary commissioning of mandatory services	-	-	-	-
Other clinical income from mandatory services	-	-	-	-
Ambulance services				
A & E income	-	-	-	-
Patient transport services income	-	-	-	-
Other income	-	-	-	-
Community services				
Block contract / system envelope income	27,546	27,592	27,546	27,592
Income from other sources (e.g. local authorities)	2,042	320	2,042	320
All services				
Private patient income	668	327	668	327
Elective recovery fund**	4,643	-	4,643	-
Additional pension contribution central funding***	12,137	11,274	12,137	11,274
Other clinical income *	2,641	12,300	2,022	11,720
Total income from activities	**463,976**	**401,083**	**463,261**	**400,499**

* Other NHS clinical income includes Provider to Provider income for services provided to other Trusts. Other clinical income includes Injury Cost Recovery Scheme income, Overseas Visitor income and non-NHS clinical income including from Primary Care Networks and Hospices. 2020/21 Other Clinical Income has been restated to £12,300k Group and £11,720k - Trust this is an increase of £161k which has moved from Other NHS Clinical Income.

**A further £4,517k Elective Recovery+ funding has been received in addition to the £4,643k. This income is reflected within the accounts as Block contract/system envelope funding received from Clinical commissioning groups.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	Group		Trust	
	2021/22	**2020/21**	**2021/22**	**2020/21**
Income from patient care activities received from:	**£000**	**£000**	**£000**	**£000**
NHS England	47,469	47,986	47,469	47,986
Clinical commissioning groups	407,327	345,606	407,327	345,606
Department of Health and Social Care	-	-	-	-
Other NHS providers	3,830	878	3,734	873
NHS other	0	-	0	-
Local authorities	2,042	2,000	2,042	2,000
Non-NHS: private patients	668	327	668	327
Non-NHS: overseas patients (chargeable to patient)	128	91	128	91
Injury cost recovery scheme	1,210	1,069	1,210	1,069
Non NHS: other	1,303	3,126	684	2,547
Total income from activities	**463,976**	**401,083**	**463,261**	**400,499**
Of which:				
Related to continuing operations	463,976	401,083	463,261	400,499
Related to discontinued operations	-	-	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	Group and Trust	
	2021/22	2020/21
	£000	£000
Income recognised this year	128	91
Cash payments received in-year	21	23
Amounts added to provision for impairment of receivables	89	69
Amounts written off in-year	90	-

Note 4 Other operating income

	Group 2021/22			Group 2020/21			Trust 2021/22			Trust 2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Research and development	1,168	-	**1,168**	1,068	-	**1,068**	1,168	-	**1,168**	1,068	-	**1,068**
Education and training	15,038	682	**15,720**	13,806	587	**14,393**	15,038	682	**15,720**	13,806	587	**14,393**
Non-patient care services to other bodies**	15,461		**15,461**	11,606		**11,606**	15,381		**15,381**	11,603		**11,603**
Reimbursement and top up funding *	6,703		**6,703**	37,843		**37,843**	6,703		**6,703**	37,843		**37,843**
Income in respect of employee benefits accounted on a gross basis	-		**-**	-		**-**	-		**-**	-		**-**
Receipt of capital grants and donations		927	**927**		2,463	**2,463**		927	**927**		2,463	**2,463**
Charitable and other contributions to expenditure		1,737	**1,737**		5,111	**5,111**		1,737	**1,737**		5,111	**5,111**
Support from the Department of Health and Social Care for mergers		-	**-**		-	**-**		-	**-**		-	**-**
Rental revenue from finance leases		-	**-**		-	**-**		-	**-**		-	**-**
Rental revenue from operating leases		252	**252**		239	**239**		127	**127**		128	**128**
Amortisation of PFI deferred income / credits		-	**-**		-	**-**		-	**-**		-	**-**
Other income***	14,231	-	**14,231**	17,409	-	**17,409**	16,395	-	**16,395**	17,591	-	**17,591**
Total other operating income	**52,601**	**3,599**	**56,200**	**81,731**	**8,400**	**90,132**	**54,686**	**3,474**	**58,160**	**81,911**	**8,289**	**90,201**
Of which:												
Related to continuing operations			56,200			90,132			58,160			90,201
Related to discontinued operations			-			-			-			-

* There has been a re-categorisation of the block top up funding in 2021/22 and this is now included within 'Income from patient care activities' as part of 'Block contract / system envelope income'.

** Non-patient care services to other bodies includes £10.1m income for The Health Informatics Service for IT services provided to other bodies and £4.253m income for Corporate Services for recharges to other bodies for use of buildings, including £3.371m to South West Yorkshire Partnerships Foundation Trust for use of the Dales unit.(In 2020/21 the Compartive figures were Group - £7.8m income for The Health Informatics Service for IT services provided to other bodies and £3.612m income for Corporate Services for recharges to other bodies for use of buildings, including £3.371m to South West Yorkshire Partnerships Foundation Trust for use of the Dales unit.

*** Group- Other contract income of £14.228m includes £11.48m sales of manufactured pharmaceutical products, £0.140m property rental income, £0.798m catering income, £0.313m car parking income (In 2020/21 the comparative figures were Group- Other contract income of £17.409m includes £15m sales of manufactured pharmaceutical products, £0.163m property rental income, £0.565m catering income, £0.03 Car parking Income)Trust - also includes income recevied from the subsidiary.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period - (Group and Trust)

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,443	2,320
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods		

Note 5.2 Transaction price allocated to remaining performance obligations

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	£000	£000	£000	£000
within one year	7,450	4,682	7,450	4,682
after one year, not later than five years	399	410	399	410
after five years	387	483	387	483
Total revenue allocated to remaining performance obligations	**8,236**	**5,575**	**8,236**	**5,575**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services - (Group and Trust)

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2021/22	2020/21
	£000	£000
Income from services designated as commissioner requested services	414,653	350,428
Income from services not designated as commissioner requested services	49,323	50,656
Total	**463,976**	**401,084**

Note 5.4 Profits and losses on disposal of property, plant and equipment

The Trust disposed of Equipment in 2021/22 with a total loss of £108k, this was made up of a Loss recognised on return of donated COVID assets to DHSC of £113k, offset by a profit on disposal of £5k (£299k profit 2020/21)

Note 5.5 Fees and charges

The Trust does not have Income from fees and charges levied by the trust where the full cost exceeds £1 million.

Note 6.1 Operating expenses

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,090	2,896	3,068	2,875
Purchase of healthcare from non-NHS and non-DHSC bodies	4,902	1,374	3,357	672
Purchase of social care	-	-	-	-
Staff and executive directors costs	325,553	301,480	314,625	290,718
Remuneration of non-executive directors	156	143	156	143
Supplies and services - clinical (excluding drugs costs)	39,924	33,218	7,644	6,849
Supplies and services - general	3,523	8,395	703	4,149
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	43,090	40,958	42,910	40,660
Inventories written down	0	66	0	66
Consultancy costs	228	867	228	252
Establishment	4,221	3,672	2,230	1,967
Premises	24,959	24,922	79,540	72,340
Transport (including patient travel)	1,036	996	369	205
Depreciation on property, plant and equipment	10,620	9,775	10,533	9,720
Amortisation on intangible assets	2,872	1,233	2,872	1,233
Net impairments	318	12,920	318	12,920
Movement in credit loss allowance: contract receivables / contract assets	121	655	121	655
Movement in credit loss allowance: all other receivables and investments	-	-	-	-
Increase/(decrease) in other provisions	1,426	3,914	1,426	3,914
Change in provisions discount rate(s)	24	43	24	43
Fees payable to the external auditor				
audit services- statutory audit	209	101	194	91
other auditor remuneration (external auditor only)	-	-	-	-
Internal audit costs	126	145	126	145
Clinical negligence	18,731	19,106	18,731	19,106
Legal fees	13	680	2	673
Insurance	-	-	-	-
Research and development	11	81	11	69
Education and training	1,301	1,258	972	749
Rentals under operating leases	3,287	3,378	2,878	3,079
Early retirements	-	-	-	-
Redundancy	-	-	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	13,463	13,425	13,463	13,425
Charges to operating expenditure for off-SoFP PFI / LIFT schemes	-	-	-	-
Car parking & security	-	-	-	-
Hospitality	-	-	-	-
Losses, ex gratia & special payments	-	-	-	-
Grossing up consortium arrangements	-	-	-	-
Other services, eg external payroll	-	-	-	-
Other	3,244	2,370	1,008	290
Total	**506,449**	**488,068**	**507,509**	**487,006**
Of which:				
Related to continuing operations	506,449	488,068	507,509	487,006
Related to discontinued operations	-	-	-	-

Note 6.2 Other auditor remuneration

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£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	-	-	-	-
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	**-**	**-**	**-**	**-**

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2021/22 or 2020/21.

Note 7 Impairment of assets (Group and Trust)

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Net impairments charged to operating surplus / deficit resulting from:				
Loss or damage from normal operations	-	250	-	250
Over specification of assets	-	-	-	-
Abandonment of assets in course of construction	-	-	-	-
Unforeseen obsolescence	-	-	-	-
Loss as a result of catastrophe	-	-	-	-
Changes in market price	318	12,670	318	12,670
Other	-	-	-	-
Total net impairments charged to operating surplus / deficit	**318**	**12,920**	**318**	**12,920**
Impairments charged to the revaluation reserve	(1,095)	2,192	(1,095)	2,192
Total net impairments	**(777)**	**15,111**	**(777)**	**15,111**

The impairments and reversal of impairments charged to operating costs and the revaluation reserve are due to changes in market values and all relates to Land and Buildings.

Note 8 Employee benefits

	Group		Trust	
		Restated		Restated
	2021/22	2020/21	2021/22	2020/21
	Total	Total	Total	Total
	£000	£000	£000	£000
Salaries and wages*	252,070	235,945	242,798	226,775
Social security costs*	24,077	21,875	23,373	21,239
Apprenticeship levy*	1,208	1,095	1,177	1,067
Employer's contributions to NHS pensions*	40,779	38,338	39,895	37,437
Pension cost - other	130	106	92	81
Other post employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Temporary staff (including agency)	7,636	4,529	7,636	4,529
Total gross staff costs	**325,900**	**301,889**	**314,972**	**291,127**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**325,900**	**301,889**	**314,972**	**291,127**
Of which				
Costs capitalised as part of assets	348	409	348	409

The 2020/21 costs have been restated for both Group and Trust to correct classification of costs, table below details the changes.

	Group			Trust		
20/21	**Orginal**	**Restated**	**Movement**	**Orginal**	**Restated**	**Movement**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages*	239922	235945	-3977	230751	226775	-3977
Social security costs*	20148	21875	1727	19512	21239	1727
Apprenticeship levy*	1008	1095	88	979	1067	88
Employer's contributions to NHS pensions*	36176	38338	2161	35275	37437	2161
			0			**0**

Note 8.1 Retirements due to ill-health (Group)

During 2021/22 there were no early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is 0k (£108k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Other Pension costs

The Foundation Trust Group offers an additional defined contribution workplace pension scheme, the National Employment Savings Scheme (NEST) for those staff ineligible to contribute to the NHS Pension.

The cost to the Foundation Trust of participating in the scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Employer's contributions to NEST - Group 21/22 £0.130m (20/21 £0.106m) Trust - 21/22 £0.092 (20/21 £0.080m)

Note 10 Operating leases (Group and Trust)

Note 10.1 Calderdale & Huddersfield NHS Foundation Trust as a lessor

This note discloses income generated in operating lease agreements where Calderdale & Huddersfield NHS Foundation Trust is the lessor.

The lease revenue is for property leased to other organisations.

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Operating lease revenue				
Minimum lease receipts	251	239	126	128
Contingent rent	1	0	1	0
Other	-	-	-	-
Total	**252**	**239**	**127**	**128**

	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Future minimum lease receipts due:				
- not later than one year;	60	59	48	48
- later than one year and not later than five years;	53	101	8	56
- later than five years.	47	59	-	-
Total	**160**	**218**	**56**	**103**

Note 10.2 Calderdale & Huddersfield NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Calderdale & Huddersfield NHS Foundation Trust is the lessee.

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Operating lease expense				
Minimum lease payments	3,293	3,383	2,884	3,084
Contingent rents	-	-	-	-
Less sublease payments received	(6)	(5)	(6)	(5)
Total	**3,287**	**3,378**	**2,878**	**3,079**

	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Future minimum lease payments due:				
- not later than one year;	2,584	2,915	2,236	2,663
- later than one year and not later than five years;	8,768	7,684	7,798	6,901
- later than five years.	11,456	14,063	10,475	12,821
Total	**22,809**	**24,662**	**20,509**	**22,384**
Future minimum sublease payments to be received	(14)	(21)	(14)	(21)

Of the operating lease expenditure £1.9m is for the leasing of buildings (£1.9m 2020/21), £1.4m is for the leasing of plant and machinery (£1.5m 2020/21).

Note 11 Finance income (Group and Trust)

Finance income represents interest received on assets and investments in the period.

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Interest on bank accounts	21	6	20	6
Interest income on finance leases	-	-	3,339	3,563
Interest on other investments / financial assets	63	35	63	35
Other finance income	-	-	-	-
Total finance income	**84**	**41**	**3,423**	**3,604**

Note 12.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Interest expense:				
Loans from the Department of Health and Social Care	435	488	435	488
Other loans	-	-	-	-
Overdrafts	-	-	-	-
Finance leases	-	-	3,985	4,290
Interest on late payment of commercial debt	0	1	0	1
Main finance costs on PFI and LIFT schemes obligations	6,032	6,188	6,032	6,188
Contingent finance costs on PFI and LIFT scheme obligations	6,483	5,544	6,483	5,544
Total interest expense	**12,950**	**12,221**	**16,935**	**16,512**
Unwinding of discount on provisions	-	-	-	-
Other finance costs	-	-	-	-
Total finance costs	**12,950**	**12,221**	**16,935**	**16,512**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Total liability accruing in year under this legislation as a result of late payments	-	-	-	-
Amounts included within interest payable arising from claims made under this legislation	0	1	0	1
Compensation paid to cover debt recovery costs under this legislation	-	-	-	-

Note 13 Other gains / (losses)

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Gains on disposal of assets	7	304	7	304
Losses on disposal of assets	(115)	(6)	(115)	(6)
Total gains / (losses) on disposal of assets	**(108)**	**298**	**(108)**	**298**
Gains / (losses) on foreign exchange	-	-	-	-
Fair value gains / (losses) on investment properties	-	-	-	-
Fair value gains / (losses) on financial assets / investments	-	-	-	-
Fair value gains / (losses) on financial liabilities	-	-	-	-
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	-	-	-	-
Other gains / (losses)	-	-	-	-
Total other gains / (losses)	**(108)**	**298**	**(108)**	**298**

Note 14 Discontinued operations (Group and Trust)

The Trust had no discontinued operations to disclose in 2021/22 or 2020/21

Note 15.1 Intangible assets - 2021/22

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**254**	**12,540**	**(0)**	**12,794**
Transfers by absorption	-	-	-	**-**
Additions	-	615	-	**615**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2022	**254**	**13,155**	**(0)**	**13,409**
Amortisation at 1 April 2021 - brought forward	**222**	**4,415**	**-**	**4,637**
Transfers by absorption	-	-	-	**-**
Provided during the year	15	2,857	-	**2,872**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2022	**237**	**7,272**	**-**	**7,510**
Net book value at 31 March 2022	**16**	**5,882**	**(0)**	**5,899**
Net book value at 1 April 2021	**31**	**8,125**	**(0)**	**8,156**

Note 15.2 Intangible assets - 2020/21

Group	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**254**	**10,237**	**1,440**	**11,930**
Transfers by absorption	-	-	-	**-**
Additions	-	863	-	**863**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	1,440	(1,440)	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2021	**254**	**12,540**	**(0)**	**12,794**
Amortisation at 1 April 2020 - as previously stated	**208**	**3,197**	**-**	**3,405**
Prior period adjustments	-	-	-	**-**
Amortisation at 1 April 2020 - restated	**208**	**3,197**	**-**	**3,405**
Transfers by absorption	-	-	-	**-**
Provided during the year	15	1,218	-	**1,233**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2021	**222**	**4,415**	**-**	**4,637**
Net book value at 31 March 2021	**31**	**8,125**	**(0)**	**8,156**
Net book value at 1 April 2020	**46**	**7,040**	**1,440**	**8,526**

Note 16.1 Intangible assets - 2021/22

Trust	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**254**	**12,540**	**(0)**	**12,794**
Transfers by absorption	-	-	-	**-**
Additions	-	615	-	**615**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2022	**254**	**13,155**	**(0)**	**13,409**
Amortisation at 1 April 2021 - brought forward	**222**	**4,415**	**-**	**4,637**
Transfers by absorption	-	-	-	**-**
Provided during the year	15	2,857	-	**2,872**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2022	**237**	**7,272**	**-**	**7,510**
Net book value at 31 March 2022	**16**	**5,882**	**(0)**	**5,899**
Net book value at 1 April 2021	**31**	**8,125**	**(0)**	**8,156**

Note 16.2 Intangible assets - 2020/21

Trust	Software licences	Internally generated information technology	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 - as previously stated	**254**	**10,237**	**1,440**	**11,930**
Transfers by absorption	-	-	-	**-**
Additions	-	863	-	**863**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	1,440	(1,440)	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Valuation / gross cost at 31 March 2021	**254**	**12,540**	**(0)**	**12,794**
Amortisation at 1 April 2020 - as previously stated	**208**	**3,197**	**-**	**3,405**
Transfers by absorption	-	-	-	**-**
Provided during the year	15	1,218	-	**1,233**
Impairments	-	-	-	**-**
Reversals of impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Reclassifications	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	**-**
Disposals / derecognition	-	-	-	**-**
Amortisation at 31 March 2021	**222**	**4,415**	**-**	**4,637**
Net book value at 31 March 2021	**31**	**8,125**	**(0)**	**8,156**
Net book value at 1 April 2020	**46**	**7,040**	**1,440**	**8,526**

Note 17.1 Property, plant and equipment - 2021/22

Group	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 2021 - brought forward	**10,160**	**115,158**	**(0)**	**8,329**	**43,008**	**85**	**35,734**	**2,335**	**214,808**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	5,215	-	5,937	4,985	-	7,562	52	**23,751**
Impairments	-	(2,770)	-	-	-	-	-	-	**(2,770)**
Reversals of impairments	800	2,747	-	-	-	-	-	-	**3,547**
Revaluations	-	(3,815)	-	-	-	-	-	-	**(3,815)**
Reclassifications	-	791	-	(2,933)	175	-	1,498	469	**0**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(906)	-	-	-	**(906)**
Valuation/gross cost at 31 March 2022	**10,960**	**117,325**	**(0)**	**11,334**	**47,262**	**85**	**44,794**	**2,856**	**234,615**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**0**	**(0)**	**-**	**27,216**	**67**	**22,247**	**1,775**	**51,306**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,815	-	-	3,183	8	3,530	83	**10,620**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(3,815)	-	-	-	-	-	-	**(3,815)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(791)	-	-	-	**(791)**
Accumulated depreciation at 31 March 2022	**-**	**0**	**(0)**	**-**	**29,609**	**75**	**25,778**	**1,858**	**57,319**
Net book value at 31 March 2022	**10,960**	**117,325**	**(0)**	**11,334**	**17,653**	**10**	**19,016**	**998**	**177,296**
Net book value at 1 April 2021	**10,160**	**115,158**	**(0)**	**8,329**	**15,791**	**18**	**13,487**	**559**	**163,503**

Note 17.2 Property, plant and equipment - 2020/21

Group	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 2020 - as previously stated	**9,400**	**122,880**	**574**	**3,439**	**36,823**	**85**	**31,978**	**2,293**	**207,472**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	10,909	-	5,239	6,197	-	3,757	41	**26,144**
Impairments	-	(15,152)	(557)	-	-	-	-	-	**(15,710)**
Reversals of impairments	760	88	-	-	-	-	-	-	**848**
Revaluations	-	(3,916)	(17)	-	-	-	-	-	**(3,933)**
Reclassifications	-	349	-	(349)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(13)	-	-	-	**(13)**
Valuation/gross cost at 31 March 2021	**10,160**	**115,158**	**(0)**	**8,329**	**43,008**	**85**	**35,734**	**2,335**	**214,808**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**0**	**(0)**	**-**	**24,797**	**59**	**18,919**	**1,696**	**45,471**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,916	17	-	2,426	8	3,328	80	**9,775**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(3,916)	(17)	-	-	-	-	-	**(3,933)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(7)	-	-	-	**(7)**
Accumulated depreciation at 31 March 2021	**-**	**0**	**(0)**	**-**	**27,216**	**67**	**22,247**	**1,775**	**51,306**
Net book value at 31 March 2021	**10,160**	**115,158**	**(0)**	**8,329**	**15,791**	**18**	**13,487**	**559**	**163,503**
Net book value at 1 April 2020	**9,400**	**122,880**	**574**	**3,439**	**12,026**	**26**	**13,058**	**598**	**162,001**

Note 17.3 Property, plant and equipment financing - 2021/22

Group	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 2022									
Owned - purchased	10,960	53,634	(0)	11,334	14,978	10	19,016	998	**110,930**
Finance leased	-	-	-	-	24	-	-	-	**24**
On-SoFP PFI contracts and other service concession arrangements	-	62,841	-	-	-	-	-	-	**62,841**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	850	-	-	2,651	-	-	-	**3,501**
NBV total at 31 March 2022	**10,960**	**117,325**	**(0)**	**11,334**	**17,653**	**10**	**19,016**	**998**	**177,296**

Note 17.4 Property, plant and equipment financing - 2020/21

Group	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 2021									
Owned - purchased	10,160	52,572	(0)	8,329	13,377	18	13,479	559	**98,494**
Finance leased	-	-	-	-	36	-	-	-	**36**
On-SoFP PFI contracts and other service concession arrangements	-	61,708	-	-	-	-	-	-	**61,708**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	878	-	-	2,379	-	8	-	**3,265**
NBV total at 31 March 2021	**10,160**	**115,158**	**(0)**	**8,329**	**15,791**	**18**	**13,487**	**559**	**163,503**

Note 18.1 Property, plant and equipment - 2021/22

Trust	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 2021 - brought forward	**10,160**	**115,158**	**(0)**	**8,329**	**42,428**	**31**	**35,674**	**2,328**	**214,107**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	5,215	-	5,937	4,875	-	7,562	52	**23,640**
Impairments	-	(2,770)	-	-	-	-	-	-	**(2,770)**
Reversals of impairments	800	2,747	-	-	-	-	-	-	**3,547**
Revaluations	-	(3,815)	-	-	-	-	-	-	**(3,815)**
Reclassifications	-	791	-	(2,933)	175	-	1,498	469	**0**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(906)	-	-	-	**(906)**
Valuation/gross cost at 31 March 2022	**10,960**	**117,325**	**(0)**	**11,334**	**46,571**	**31**	**44,734**	**2,849**	**233,803**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**0**	**(0)**	**-**	**27,054**	**31**	**22,199**	**1,775**	**51,058**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,815	-	-	3,117	-	3,518	83	**10,533**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(3,815)	-	-	-	-	-	-	**(3,815)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(791)	-	-	-	**(791)**
Accumulated depreciation at 31 March 2022	**-**	**0**	**(0)**	**-**	**29,380**	**31**	**25,717**	**1,858**	**56,985**
Net book value at 31 March 2022	**10,960**	**117,325**	**(0)**	**11,334**	**17,192**	**0**	**19,017**	**991**	**176,818**
Net book value at 1 April 2021	**10,160**	**115,158**	**(0)**	**8,329**	**15,374**	**0**	**13,475**	**553**	**163,049**

Note 18.2 Property, plant and equipment - 2020/21

Trust	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 2020 - as previously stated	**9,400**	**122,880**	**574**	**3,439**	**36,463**	**31**	**31,918**	**2,286**	**206,990**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Additions	-	10,909	-	5,239	5,978	-	3,757	41	**25,925**
Impairments	-	(15,152)	(557)	-	-	-	-	-	**(15,710)**
Reversals of impairments	760	88	-	-	-	-	-	-	**848**
Revaluations	-	(3,916)	(17)	-	-	-	-	-	**(3,933)**
Reclassifications	-	349	-	(349)	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(13)	-	-	-	**(13)**
Valuation/gross cost at 31 March 2021	**10,160**	**115,158**	**(0)**	**8,329**	**42,428**	**31**	**35,674**	**2,328**	**214,107**
Accumulated depreciation at 1 April 2020 - as previously stated	**-**	**0**	**(0)**	**-**	**24,669**	**31**	**18,883**	**1,695**	**45,279**
Transfers by absorption	-	-	-	-	-	-	-	-	**-**
Provided during the year	-	3,916	17	-	2,391	-	3,316	80	**9,720**
Impairments	-	-	-	-	-	-	-	-	**-**
Reversals of impairments	-	-	-	-	-	-	-	-	**-**
Revaluations	-	(3,916)	(17)	-	-	-	-	-	**(3,933)**
Reclassifications	-	-	-	-	-	-	-	-	**-**
Transfers to / from assets held for sale	-	-	-	-	-	-	-	-	**-**
Disposals / derecognition	-	-	-	-	(7)	-	-	-	**(7)**
Accumulated depreciation at 31 March 2021	**-**	**0**	**(0)**	**-**	**27,054**	**31**	**22,199**	**1,775**	**51,058**
Net book value at 31 March 2021	**10,160**	**115,158**	**(0)**	**8,329**	**15,374**	**0**	**13,475**	**553**	**163,049**
Net book value at 1 April 2020	**9,400**	**122,880**	**574**	**3,439**	**11,793**	**0**	**13,034**	**591**	**161,711**

Note 18.3 Property, plant and equipment financing - 2021/22

Trust	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 2022									
Owned - purchased	10,960	53,634	(0)	11,334	14,517	0	19,017	991	**110,452**
Finance leased	-	-	-	-	24	-	-	-	**24**
On-SoFP PFI contracts and other service concession arrangements	-	62,841	-	-	-	-	-	-	**62,841**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	850	-	-	2,651	-	-	-	**3,501**
NBV total at 31 March 2022	**10,960**	**117,325**	**(0)**	**11,334**	**17,192**	**0**	**19,017**	**991**	**176,818**

Note 18.4 Property, plant and equipment financing - 2020/21

Trust	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 2021									
Owned - purchased	10,160	52,572	(0)	8,329	12,959	0	13,467	553	**98,040**
Finance leased	-	-	-	-	36	-	-	-	**36**
On-SoFP PFI contracts and other service concession arrangements	-	61,708	-	-	-	-	-	-	**61,708**
Off-SoFP PFI residual interests	-	-	-	-	-	-	-	-	**-**
Owned - donated/granted	-	878	-	-	2,379	-	8	-	**3,265**
NBV total at 31 March 2021	**10,160**	**115,158**	**(0)**	**8,329**	**15,374**	**0**	**13,475**	**553**	**163,049**

Note 19 Donations of property, plant and equipment

During 2021/22 the Trust received cash from Calderdale and Huddersfield Charitable Funds of £172.8k (£59k 2020/21) for items of equipment to be purchased which included: enhancement of welfare facilities, a Digital Hess Machine and additional arm boards for Cardiology. A grant of £96k was received from Innovate, to purchase equipment for Pathology. Donations totalling £0.658m (£2.403m 2020/21) of property, plant and equipment assets were received from DHSC as part of the Coronavirus pandemic response in 2021/22, which included Ventilators, Patient Monitors, Oxygen Concentrators and Syringe Drivers

Note 20 Revaluations of property, plant and equipment

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Dand and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

A full on-site valuation was carried out as at 1st April 2018. An desktop interim revaluation was undertaken as at 31 March 2022. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Note 21 Investments in associates and joint ventures

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**3,912**	**4,162**	**3,912**	**4,162**
Prior period adjustments		-		-
Carrying value at 1 April - restated	**3,912**	**4,162**	**3,912**	**4,162**
Transfers by absorption	-	-	-	-
Acquisitions in year	-	-	-	-
Share of profit / (loss)	265	-	265	-
Net impairments	-	(250)	-	(250)
Transfers to / from assets held for sale	-	-	-	-
Disbursements / dividends received	-	-	-	-
Disposals	-	-	-	-
Share of Other Comprehensive Income	-	-	-	-
Other equity movements	-	-	-	-
Carrying value at 31 March	**4,177**	**3,912**	**4,177**	**3,912**

Note 22 Other investments / financial assets (non-current)

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**-**	**-**	**1,553**	**2,543**
Prior period adjustments		-		-
Carrying value at 1 April - restated	**-**	**-**	**1,553**	**2,543**
Transfers by absorption	-	-	-	-
Acquisitions in year	-	-	-	-
Movement in fair value through income and expenditure	-	-	-	-
Movement in fair value through OCI	-	-	-	-
Net impairments	-	-	-	-
Transfers to / from assets held for sale	-	-	-	-
Amortisation at the effective interest rate	-	-	-	-
Current portion of loans receivable transferred to current financial assets	-	-	(1,026)	(990)
Disposals	-	-	-	-
Carrying value at 31 March	**-**	**-**	**527**	**1,553**

Note 22.1 Other investments / financial assets (current)

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Loans receivable within 12 months transferred from non-current financial assets	-	-	1,026	990
Deposits with the National Loans Fund	-	-	-	-
Other current financial assets	4,000	4,000	4,004	4,007
Total current investments / financial assets	**4,000**	**4,000**	**5,030**	**4,997**

Note 23 Disclosure of interests in other entities

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This partnership is the Pennine Property Partnership LLP (PPP LLP) and is owned 50/50 by the Trust and Henry Boot Development Ltd.

It 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 involved the substantial reconstruction and refurbishment of an existing derelict stone mill, known as Acre Mill, and now provides a range of modern outpatient facilities. The facility has been in use since the end of January 2015.
The Pennine Property Partnership LLP's principal place of business is within the UK.

The Trust has used the equity accounting method.

There are no contingent liabilities of the JV for which the Trust is jointly and contingently liable.

The JV has no capital commitments.

Disclosure of aggregate amounts for assets and liabilities of jointly controlled operations	**2021/22**	**2020/21**
	£000	**£000**
Non current assets	15,205	15,186
Current assets	419	1,634
Total assets	**15,624**	**16,820**
Current liabilities	(4,675)	(6,424)
Non current liabilities	(2,595)	(2,573)
Total liabilities	**(7,270)**	**(8,997)**
Net Assets Attributable to members	**8,354**	**7 ,823**
Operating income	769	736
Operating expenses	(200)	(168)
Fair Value revaluation Gain	-	207
Surplus /(deficit) for the year	**569**	**775**

Note 24 Inventories

	Group		**Trust**	
	31 March 2022	**31 March 2021**	**31 March 2022**	**31 March 2021**
	£000	**£000**	**£000**	**£000**
Drugs	2,437	2,298	1,895	1,756
Work In progress	212	336	212	336
Consumables	4,963	4,824	3,353	3,338
Energy	-	-	-	-
Other	-	-	-	-
Total inventories	**7,612**	**7,458**	**5,460**	**5,430**
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £82,450k (2020/21: £67,256k). Write-down of inventories recognised as expenses for the year were £0k (2020/21: £66k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,311k of items purchased by DHSC (2020/21: £4,691k).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 25.1 Receivables

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Contract receivables	17,623	15,009	18,778	17,842
Contract assets	-	-	-	-
Capital receivables	82	79	82	79
Allowance for impaired contract receivables / assets	(1,661)	(1,956)	(1,661)	(1,956)
Allowance for other impaired receivables	-	-	-	-
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	4,525	4,210	2,991	3,436
PFI prepayments - capital contributions	-	-	-	-
PFI lifecycle prepayments	-	-	-	-
Interest receivable	-	-	-	-
Finance lease receivables	-	-	3,833	3,633
PDC dividend receivable	453	689	453	689
VAT receivable	1,741	2,700	1,790	2,004
Corporation and other taxes receivable	-	-	-	-
Other receivables	-	-	-	-
Total current receivables	**22,762**	**20,731**	**26,266**	**25,727**
Non-current				
Contract receivables	3,212	3,371	3,212	3,371
Contract assets	-	-	-	-
Capital receivables	1,279	1,358	1,279	1,358
Allowance for impaired contract receivables / assets	(671)	(821)	(671)	(821)
Allowance for other impaired receivables	-	-	-	-
Deposits and advances	-	-	-	-
Prepayments (non-PFI)	-	-	-	-
PFI prepayments - capital contributions	-	-	-	-
PFI lifecycle prepayments	-	-	-	-
Interest receivable	-	-	-	-
Finance lease receivables	-	-	54,950	58,784
VAT receivable	696	-	696	-
Corporation and other taxes receivable	-	-	-	-
Other receivables	-	-	-	-
Total non-current receivables	**4,515**	**3,908**	**59,466**	**62,692**
Of which receivable from NHS and DHSC group bodies:				
Current	10,721	8,564	10,632	8,564
Non-current	-	-	-	-

Within receivables, £1.638m, is due to the Trust from the subsidiary CHS. The Finance lease receivables are all due to the Trust from the subsidiary CHS.

Note 25.2 Allowances for credit losses-2021/22

	Group 2021/22		Trust 2021/22	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,777**	**-**	**2,777**	**-**
Prior period adjustments				
Allowances as at 1 April - restated	**2,777**	**-**	**2,777**	**-**
Transfers by absorption	-	-	-	-
New allowances arising	226	-	226	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	(105)	-	(105)	-
Utilisation of allowances (write offs)	(566)	-	(566)	-
Changes arising following modification of contractual cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2022	**2,332**	**-**	**2,332**	**-**

Note 25.3 Allowances for credit losses-2020/21

	Group 2020/21		Trust 2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**2,439**	**-**	**2,439**	**-**
Prior period adjustments	-	-	-	-
Allowances as at 1 April - restated	**2,439**	**-**	**2,439**	**-**
Allowances at start of period for new FTs	-	-	-	-
Transfers by absorption	-	-	-	-
New allowances arising	655	-	655	-
Changes in existing allowances	-	-	-	-
Reversals of allowances	-	-	-	-
Utilisation of allowances (write offs)	(316)	-	(316)	-
cash flows	-	-	-	-
Foreign exchange and other changes	-	-	-	-
Allowances as at 31 Mar 2022	**2,777**	**-**	**2,777**	**-**

Note 26 Other assets

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
Current	£000	£000	£000	£000
Other assets	-	-	-	-
Total other current assets	-	-	-	-
Non-current				
Net defined benefit pension scheme asset	-	-	-	-
Other assets	-	-	-	-
Total other non-current assets	-	-	-	-

Note 27.1 Non-current assets held for sale and assets in disposal groups

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April	275	1,114	275	1,114
Prior period adjustment		-		-
NBV of non-current assets for sale and assets in disposal groups at 1 April - restated	275	1,114	275	1,114
Transfers by absorption	-	-	-	-
Assets classified as available for sale in the year	-	-	-	-
Assets sold in year	-	(839)	-	(839)
Impairment of assets held for sale	-	-	-	-
Reversal of impairment of assets held for sale	-	-	-	-
Assets no longer classified as held for sale, for reasons other than sale	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	275	275	275	275

The assets classified as held for sale as at 31 March 2022 comprised one asset of land and buildings namely: 62 Acre Street (GP Surgery).

Note 27.2 Liabilities in disposal groups

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Categorised as:				
Provisions	-	-	-	-
Trade and other payables	-	-	-	-
Other	-	-	-	-
Total	-	-	-	-

Note 28.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
At 1 April	**48,222**	**9,289**	**46,958**	**7,655**
Transfers by absorption	-	-	-	-
Net change in year	6,522	38,933	5,463	39,304
At 31 March	**54,744**	**48,222**	**52,422**	**46,958**
Broken down into:				
Cash at commercial banks and in hand	108	1,327	59	64
Cash with the Government Banking Service	54,635	46,895	52,363	46,895
Deposits with the National Loan Fund	-	-	-	-
Other current investments	-	-	-	-
Total cash and cash equivalents as in SoFP	**54,744**	**48,222**	**52,422**	**46,958**
Bank overdrafts (GBS and commercial banks)	-	-	-	-
Drawdown in committed facility	-	-	-	-
Total cash and cash equivalents as in SoCF	**54,744**	**48,222**	**52,422**	**46,958**

Note 28.2 Third party assets held by the trust

Calderdale & Huddersfield NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2022	31 March 2021
	£000	£000
Bank balances	-	-
Monies on deposit	8	8
Total third party assets	**8**	**8**

Note 29.1 Trade and other payables

	Group		Trust	
	31 March 2022 £000	31 March 2021 £000	31 March 2022 £000	31 March 2021 £000
Current				
Trade payables	15,173	10,464	11,755	7,612
Capital payables	16,722	12,678	16,721	12,678
Accruals	32,855	28,872	34,182	34,650
Receipts in advance and payments on account	-	530	-	530
PFI lifecycle replacement received in advance	-	-	-	-
Social security costs	7,107	6,040	6,931	5,889
VAT payables	-	-	-	-
Other taxes payable	-	-	-	-
PDC dividend payable	1	1	1	1
Other payables	4,890	5,146	2,450	326
Total current trade and other payables	**76,748**	**63,731**	**72,039**	**61,685**
Non-current				
Trade payables	-	-	-	-
Capital payables	-	-	-	-
Accruals	-	-	-	-
Receipts in advance and payments on account	-	-	-	-
PFI lifecycle replacement received in advance	-	-	-	-
VAT payables	-	-	-	-
Other taxes payable	-	-	-	-
Other payables	107	97	107	97
Total non-current trade and other payables	**107**	**97**	**107**	**97**
Of which payables from NHS and DHSC group bodies:				
Current	2,137	2,930	2,073	2,930
Non-current	-	-	-	-

Within payables £2.045m is owed to the subsidiary CHS from the Trust.

Note 29.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2022 £000	31 March 2022 Number	31 March 2021 £000	31 March 2021 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-

Note 30 Other liabilities

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	7,450	4,682	7,450	4,682
Deferred grants	-	-	-	-
Deferred PFI credits / income	-	-	-	-
Lease incentives	-	-	-	-
Other deferred income	-	-	-	-
Total other current liabilities	**7,450**	**4,682**	**7,450**	**4,682**
Non-current				
Deferred income: contract liabilities	785	893	785	893
Deferred grants	-	-	-	-
Deferred PFI credits / income	-	-	-	-
Lease incentives	-	-	-	-
Other deferred income	-	-	-	-
Net pension scheme liability	-	-	-	-
Total other non-current liabilities	**785**	**893**	**785**	**893**

Note 31.1 Borrowings

	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Current				
Bank overdrafts	-	-	-	-
Drawdown in committed facility	-	-	-	-
Loans from DHSC	2,359	2,378	2,359	2,378
Other loans	-	-	-	-
Obligations under finance leases	8	8	12,098	4,457
Obligations under PFI, LIFT or other service concession contracts	3,484	3,023	3,484	3,023
Total current borrowings	**5,851**	**5,410**	**17,940**	**9,858**
Non-current				
Loans from DHSC	15,462	17,670	15,462	17,670
Other loans	-	-	-	-
Obligations under finance leases	24	33	48,873	60,970
Obligations under PFI, LIFT or other service concession contracts	64,362	67,845	64,362	67,845
Total non-current borrowings	**79,848**	**85,548**	**128,697**	**146,485**

Note 31.2 Reconciliation of liabilities arising from financing activities - 2021/22

Group	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**20,048**	**-**	**41**	**70,868**	**90,957**
Cash movements:					
Financing cash flows - payments and receipts of principal	(2,208)	-	(8)	(3,022)	**(5,238)**
Financing cash flows - payments of interest	(454)	-	-	(6,032)	**(6,486)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	435	-	-	6,032	**6,467**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2022	**17,821**	**-**	**33**	**67,846**	**85,700**

Note 31.3 Reconciliation of liabilities arising from financing activities - 2020/21

Group	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**163,601**	**-**	**49**	**72,701**	**236,351**
Prior period adjustment	-	-	-	-	**-**
Carrying value at 1 April 2020 - restated	**163,601**	**-**	**49**	**72,701**	**236,351**
Cash movements:					
Financing cash flows - payments and receipts of principal	(142,926)	-	(8)	(1,833)	**(144,767)**
Financing cash flows - payments of interest	(1,115)	-	-	(6,188)	**(7,303)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	488	-	-	6,188	**6,676**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2021	**20,048**	**-**	**41**	**70,868**	**90,957**

Note 32 Other financial liabilities

	31 March 2022	31 March 2021
	£000	£000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total current other financial liabilities	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total non-current other financial liabilities	**-**	**-**

Note 32.1 Reconciliation of liabilities arising from financing activities - 2021/22

Trust	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2021	**20,048**	**-**	**65,427**	**70,868**	**156,343**
Cash movements:					
Financing cash flows - payments and receipts of principal	(2,208)	-	(4,458)	(3,022)	**(9,688)**
Financing cash flows - payments of interest	(454)	-	(3,985)	(6,032)	**(10,471)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	435	-	3,985	6,032	**10,452**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2022	**17,821**	**-**	**60,970**	**67,846**	**146,637**

Note 32.2 Reconciliation of liabilities arising from financing activities - 2020/21

Trust	Loans from DHSC	Other loans	Finance leases	PFI and LIFT schemes	Total
	£000	£000	£000	£000	£000
Carrying value at 1 April 2020	**163,601**	**-**	**69,578**	**72,701**	**305,880**
Prior period adjustment	-	-	-	-	**-**
Carrying value at 1 April 2020 - restated	**163,601**	**-**	**69,578**	**72,701**	**305,880**
Cash movements:					
Financing cash flows - payments and receipts of principal	(142,926)	-	(4,153)	(1,833)	**(148,912)**
Financing cash flows - payments of interest	(1,115)	-	(4,288)	(6,188)	**(11,591)**
Non-cash movements:					
Transfers by absorption	-	-	-	-	**-**
Additions	-	-	-	-	**-**
Application of effective interest rate	488	-	4,290	6,188	**10,966**
Change in effective interest rate	-	-	-	-	**-**
Changes in fair value	-	-	-	-	**-**
Early terminations	-	-	-	-	**-**
Other changes	-	-	-	-	**-**
Carrying value at 31 March 2021	**20,048**	**-**	**65,427**	**70,868**	**156,343**

Note 33 Other financial liabilities

	31 March 2022	31 March 2021
	£000	£000
Current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total current other financial liabilities	**-**	**-**
Non-current		
Derivatives held at fair value through income and expenditure	-	-
Other financial liabilities	-	-
Total non-current other financial liabilities	**-**	**-**

Note 33 Finance leases

Note 33.1 Calderdale & Huddersfield NHS Foundation Trust as a lessor

Future lease receipts due under finance lease agreements where the trust is the lessor:

This is for Building leases with the Subsidiary

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Gross lease receivables	**-**	**-**	**78,799**	**85,701**
of which those receivable:				
- not later than one year;	-	-	6,902	6,902
- later than one year and not later than five years;	-	-	27,608	27,608
- later than five years.	-	-	44,289	51,191
Unearned interest income	-	-	(20,015)	(23,285)
Allowance for uncollectable lease payments	-	-	-	-
Net lease receivables	**-**	**-**	**58,784**	**62,417**
of which those receivable:				
- not later than one year;	-	-	3,833	3,633
- later than one year and not later than five years;	-	-	17,567	16,649
- later than five years.	-	-	37,383	42,135
The unguaranteed residual value accruing to the lessor	-	-	-	-
Contingent rents recognised as income in the period	-	-	-	-

Note 33.2 Calderdale & Huddersfield NHS Foundation Trust as a lessee

Obligations under finance leases where the trust is the lessee.

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Gross lease liabilities	**33**	**41**	**84,455**	**92,896**
of which liabilities are due:				
- not later than one year;	8	8	8,444	8,443
- later than one year and not later than five years;	24	33	29,508	30,703
- later than five years.	-	-	46,503	53,750
Finance charges allocated to future periods	-	-	-	-
Net lease liabilities	**33**	**41**	**84,455**	**92,896**
of which payable:				
- not later than one year;	8	8	-	-
- later than one year and not later than five years;	24	33	-	-
- later than five years.	-	-	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-	-	-
Contingent rent recognised as expense in the period	-	-	-	-

The Trust lease payable is for building leases with the Subsidiary.

Note 34.1 Provisions for liabilities and charges analysis - Group

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other*	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2021	**574**	**937**	**91**	**813**	**-**	**-**	**5,196**	**7,612**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	4	20	-	-	-	-	-	**24**
Arising during the year	213	75	38	-	-	-	1,908	**2,234**
Utilised during the year	(228)	(88)	(36)	-	-	-	(186)	**(538)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	(27)	(54)	(46)	(303)	-	-	(257)	**(687)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2022	**536**	**890**	**47**	**510**	**-**	**-**	**6,661**	**8,645**
Expected timing of cash flows:								
- not later than one year;	224	80	47	475	-	-	6,661	**7,487**
- later than one year and not later than five years;	37	11	-	-	-	-	-	**48**
- later than five years.	275	799	0	35	-	-	0	**1,110**
Total	**536**	**890**	**47**	**510**	**-**	**-**	**6,661**	**8,645**

* Other Provisions includes £2.655m for Working Time Directive claims, £1.798m Legal Fees, £0.910m Clinicians Pension tax reimbursement provisions and £0.908m NHS Pensions Final Salary Pay Controls.

Note 34.2 Provisions for liabilities and charges analysis Trust

	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other*	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2021	**574**	**937**	**91**	**813**	**-**	**-**	**5,196**	**7,612**
At start of period for new FTs	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
Transfers by absorption	-	-	-	-	-	-	-	**-**
Change in the discount rate	4	20	-	-	-	-	-	**24**
Arising during the year	213	75	38	-	-	-	1,908	**2,234**
Utilised during the year	(228)	(88)	(36)	-	-	-	(186)	**(538)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	**-**
Reversed unused	(27)	(54)	(46)	(303)	-	-	(257)	**(687)**
Unwinding of discount	-	-	-	-	-	-	-	**-**
At 31 March 2022	**536**	**890**	**47**	**510**	**-**	**-**	**6,661**	**8,645**
Expected timing of cash flows:								
- not later than one year;	224	80	47	475	-	-	6,661	**7,487**
- later than one year and not later than five years;	37	11	-	-	-	-	-	**48**
- later than five years.	275	799	0	35	-	-	0	**1,110**
Total	**536**	**890**	**47**	**510**	**-**	**-**	**6,661**	**8,645**

* Other Provisions includes £2.655m for Working Time Directive claims, £1.798m Legal Fees, £0.910m Clinicians Pension tax reimbursement provisions and £0.908m NHS Pensions Final Salary Pay Controls.

Note 34.2 Clinical negligence liabilities

At 31 March 2022, £270,992k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Calderdale & Huddersfield NHS Foundation Trust (31 March 2021: £207,981k).

Note 35 Contingent assets and liabilities

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	-	-	-	-
Employment tribunal and other employee related litigation	-	-	-	-
Redundancy	-	-	-	-
Other	-	-	-	-
Gross value of contingent liabilities	**-**	**-**	**-**	**-**
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	**-**	**-**	**-**	**-**
Net value of contingent assets	**-**	**-**	**-**	**-**

Note 36 Contractual capital commitments

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Property, plant and equipment	5,065	1,841	5,065	1,841
Intangible assets	-	-	-	-
Total	**5,065**	**1,841**	**5,065**	**1,841**

Note 37 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
not later than 1 year	3,022	3,022	3,022	3,022
after 1 year and not later than 5 years	6,045	9,067	6,045	9,067
paid thereafter	-	-	-	-
Total	**9,067**	**12,089**	**9,067**	**12,089**

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 and Huddersfield NHS Foundation Trust as the contract signatory. Calderdale and Huddersfield NHS Foundation Trust has a back to back legal agreement with Bradford Teaching Hospital NHS Foundation Trust to indemnify Calderdale and Huddersfield NHS Foundation Trust against any associated risk.

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has a PFI scheme for Calderdale Royal Hospital. The PFI contractor is Calderdale Hospitals SPC Ltd (formerly Catalyst Healthcare Ltd). The Trust is responsible for the provision of all clinical services, Calderdale Hospitals SPC Ltd provide fully serviced hospital accommodation.

Note 38.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Gross PFI, LIFT or other service concession liabilities	**208,986**	**226,670**	**208,986**	**226,670**
Of which liabilities are due				
- not later than one year;	16,276	15,686	16,276	15,686
- later than one year and not later than five years;	69,174	68,171	69,174	68,171
- later than five years.	123,536	142,813	123,536	142,813
Finance charges allocated to future periods	(141,140)	(155,802)	(141,140)	(155,802)
Net PFI, LIFT or other service concession arrangement obligation	**67,846**	**70,868**	**67,846**	**70,868**
- not later than one year;	3,484	3,023	3,484	3,023
- later than one year and not later than five years;	17,165	15,818	17,165	15,818
- later than five years.	47,197	52,027	47,197	52,027

Note 38.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	Group		Trust	
	31 March 2022	31 March 2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	**345,600**	**378,372**	**345,600**	**378,372**
Of which payments are due:				
- not later than one year;	29,900	29,467	29,900	29,467
- later than one year and not later than five years;	127,078	125,237	127,078	125,237
- later than five years.	188,622	223,668	188,622	223,668

Note 38.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	Group		Trust	
	2021/22	2020/21	2021/22	2020/21
	£000	£000	£000	£000
Unitary payment payable to service concession operator	**29,257**	**28,734**	**29,257**	**28,734**
Consisting of:				
- Interest charge	6,032	6,188	6,032	6,188
- Repayment of balance sheet obligation	3,022	1,833	3,022	1,833
- Service element and other charges to operating expenditure	12,963	12,676	12,963	12,676
- Capital lifecycle maintenance	257	1,744	257	1,744
- Revenue lifecycle maintenance	500	749	500	749
- Contingent rent	6,483	5,544	6,483	5,544
- 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	**29,257**	**28,734**	**29,257**	**28,734**

Note 39 Financial instruments

Note 39.1 Financial risk management

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Additional government funding to support the necessary actions to deal with the Covid-19 pandemic was also made available to the Trust in 2021/22. This will continue in 2022/23.

Financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust neither buys or sells financial instruments. The NHS Foundation Trust has limited powers to invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

Investment risk

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 (now NHS Improvement) 'Managing Operating Cash in NHS Foundation Trusts'. In addition the policy sets out the maximum limits for any such investments and the Trust's approach to borrowing. The policy, and its implementation, are reviewed by the Audit & Risk Committee and the Board of Directors. The Trust's treasury management activity is subject to review by the Trust's internal auditors.

Interest rate risk

All of the Trust's currently held financial liabilities carry nil or fixed rates of interest. The Trust therefore currently has low exposure to interest rate fluctuations.

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. In 2020/21 and 2021/22 the normal contracts were replaced by fixed block value funding received monthly, guaranteeing a level of cashflow to the Trust.

In 2021/22 the Trust has financed its capital expenditure from internally generated funds generated through depreciation charges supplemented by Public Dividend Capital received.

A change to the NHS financial architecture in 2020/21 saw the conversion of all historic revenue support borrowing and elements of historic capital loans to non repayable Public Dividend Capital (PDC). No further borrowing was required in 2021/22 and the plans for 2022/23 are forecast to be managed without extending the need for operational cash support. 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 39.2 Carrying values of financial assets - Group

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	19,863	-	-	**19,863**
Other investments / financial assets	4,000	-	-	**4,000**
Cash and cash equivalents	54,744	-	-	**54,744**
Total at 31 March 2022	**78,607**	**-**	**-**	**78,607**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	17,040	-	-	**17,040**
Other investments / financial assets	4,000	-	-	**4,000**
Cash and cash equivalents	48,222	-	-	**48,222**
Total at 31 March 2021	**69,262**	**-**	**-**	**69,262**

Note 39.3 Carrying values of financial assets - Trust

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	79,802	-	-	**79,802**
Other investments / financial assets	5,557	-	-	**5,557**
Cash and cash equivalents	52,422	-	-	**52,422**
Total at 31 March 2022	**137,781**	**-**	**-**	**137,781**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	82,930	-	-	**82,930**
Other investments / financial assets	6,550	-	No	**6,550**
Cash and cash equivalents	46,958	-	No	**46,958**
Total at 31 March 2021	**136,438**	**-**	**-**	**136,438**

Note 39.4 Carrying values of financial liabilities - Group

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	17,821	-	**17,821**
Obligations under finance leases	33	-	**33**
Obligations under PFI, LIFT and other service concession contracts	67,846	-	**67,846**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	69,746	-	**69,746**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2022	**155,445**	**-**	**155,445**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	20,048	-	**20,048**
Obligations under finance leases	41	-	**41**
Obligations under PFI, LIFT and other service concession contracts	70,868	-	**70,868**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	57,257	-	**57,257**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2021	**148,214**	**-**	**148,214**

Note 39.5 Carrying values of financial liabilities - Trust

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	17,821	-	**17,821**
Obligations under finance leases	60,970	-	**60,970**
Obligations under PFI, LIFT and other service concession contracts	67,846	-	**67,846**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	65,214	-	**65,214**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2022	**211,851**	**-**	**211,851**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	20,048	-	**20,048**
Obligations under finance leases	65,427	-	**65,427**
Obligations under PFI, LIFT and other service concession contracts	70,868	-	**70,868**
Other borrowings	-	-	**-**
Trade and other payables excluding non financial liabilities	56,003	-	**56,003**
Other financial liabilities	-	-	**-**
Provisions under contract	-	-	**-**
Total at 31 March 2021	**212,346**	**-**	**212,346**

Note 39.6 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2022	2021	31 March 2022	31 March 2021
	£000	£000	£000	£000
In one year or less	88,546	76,156	92,437	84,590
In more than one year but not more than five years	79,146	78,362	108,630	109,033
In more than five years	130,247	152,189	176,750	205,939
Total	**297,939**	**306,706**	**377,817**	**399,562**

Note 39.7 Fair values of financial assets and liabilities

The book value (carrying value of financial assets and liabilities) is a reasonable approximation of fair value.

Note 40 Losses and special payments - Group and Trust

Group and Trust	2021/22 Total number of cases Number	2021/22 Total value of cases £000	2020/21 Restated Total number of cases Number	2020/21 Restated Total value of cases £000
Losses				
Cash losses	3	2	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	2	130	-	-
Stores losses and damage to property	4	196	1	173
Total losses	**9**	**328**	**1**	**173**
Special payments				
Compensation under court order or legally binding arbitration award	14	36	19	47
Extra-contractual payments	-	-	-	-
Ex-gratia payments	24	13	27	489
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**38**	**49**	**46**	**536**
Total losses and special payments	**47**	**378**	**47**	**709**
Compensation payments received		-		-

The 20/21 number for Ex- gratia payments has been rested to include, for Overtime corrective payments (Flowers judgement) as per NHSI/E guidance, 1 case and £461k has been included for 20/21. Ongoing costs, including the impact on 2021/22 pay are not deemed special payments as these reflect determined entitlement under employment contract and so re excluded from 2021/22

Note 41 Gifts

Group and Trust	2021/22 Total number of cases Number	2021/22 Total value of cases £000	2020/21 Total number of cases Number	2020/21 Total value of cases £000
Gifts made	-	-	-	-

Note 42 Related parties

The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24.

The Department of Health and Social Care are the parent department and all bodies within the scope of 'Whole of Government Accounts' (WGA) are related parties. Accordingly, the table below details material transactions.

Related party transactions - WGA organisations	**2021/22**	**2020/21**
	£000	**£000**
Income - NHS Calderdale CCG	157,455	153,928
Income -NHS Kirklees CCG (Formerly NHS Greater Huddersfield CCG- NHS North Kirklees CCG)	149,369	145,815
Income - NHS Bradford Districts CCG	10,884	9,348
Income - NHS Wakefield CCG	96,193	37,287
Income - Leeds Teaching Hospitals NHS Trust	1,267	1,439
Income - South West Yorkshire Partnership NHS Foundation Trust	4,785	4,372
Income - Health Education England	15,590	13,798
Income- NHS Eng- Central Specialised Commissioning Hub	6,639	72,149
Income - Other WGA	49,393	17,118
Income - Total with WGA organisations	**491,575**	**455,254**
Charitable Funds	434	827
Income - Total	**492,009**	**456,081**
Expenditure - Bradford Teaching Hospitals NHS Foundation Trust	676	520
Expenditure - Leeds Teaching Hospitals NHS Trust	3,842	4,271
Expenditure - NHS Pension Scheme	40,779	35,899
Expenditure - NHS Resolution	18,990	19,389
Expenditure - HMRC	25,333	21,121
Expenditure - Other WGA	5,689	6,427
Expenditure - Total with WGA organisations	**95,309**	**87,626**
Joint Ventures	1,589	1,476
Expenditure - Total	**96,898**	**89,102**

Related party balances - WGA organisations	**2021/22**	**2020/21**
	£000	**£000**
Receivables - NHS Calderdale CCG	2,460	30
Receivables -Income -NHS Kirklees CCG - was NHS Greater Huddersfield CCG	800	8
Receivables - NHS England	3,922	4,456
Receivables - HM Revenue & Customs - VAT	2,437	2,700
Receivables - Other WGA	3,446	3,786
Charitable Funds	316	289
Receivables - Total with WGA organisations	**13,381**	**11,269**
Payables - NHS Pension Scheme	4,016	3,780
Payables - HMRC	7,107	6,040
Payables - Other WGA	3,049	3,593
Payables - Total with WGA organisations	**14,172**	**13,413**

During the year, the following Board Members or members of the key management staff have declared the following interests or parties related to them.

P Lewer ~ Chair - Not a Director of any other company. WYAAT member, member of the Partnership Transformation Board, Pennine GP & CHFT Board to Board member.

B Brown ~ Chief Executive - Started 1st Jan 2022. Not a director of any other company. Chair of West Yorkshire & Harrogate People board. Member of NHS People Plan Delivery Board. Member of NHSE/I North East & Yorkshire Regional People Board. Honorary Professor University of Bradford. Member of Bradford City Culture Board.

O Williams ~ Chief Executive - Left 31st October 2021

G Boothby ~ Director of Finance - Is a Director of Pennine Property Partnership LLP. WYAAT member. Integrated Care Systems member, member of the Partnership Transformation Board. WY Finance representative for supply chain Northern customer board.

K Archer ~ Acting Director of Finance 26th Aug 2021 - 1st Nov 2021. Not a director of any other company.

S Dunkley ~ Exec Director of Workforce & OD - Not a Director of any other company.

D Birkenhead ~ Medical Director - Director of Benson Medical Services. WYAAT member, Chair of WYAAT LIMS Procurement Group, member of YHW Diagnostics Board..

H Barker~ Chief Operating Officer - Director of a company that does not deal with public sector. Left 31st Oct 2021.

B Walker ~ Acting Chief Operating Officer 1st Oct 2021 - 30th Nov 2021 then retired.

J Fawcus ~ Chief Operating Officer started 7th Nov 2021. Not a director of any other company. Chair of West Yorkshire Cardiac Clinical Network.

R Hopkin ~ Non Executive Director - Director of Capri Finance Ltd- own consultancy company. (Hon) Treasurer Community Foundation for Calderdale, Finance Consultant Age UK Wakefield District.

K Heaton ~ Non Executive Director - Not a Director of any other company.

A Nelson~ Non Exec Director - Not a Director of any other company.

A Graham~ Non Exec Director- is a Director of Calderdale & Huddersfield Solutions Ltd.

E Armistead~ Exec Director of Nursing - Interim Chief Exec from 8th Nov 2021 to 31st Dec 2021~ Not a Director of any other company. WYAAT member, Trustee Kirkwood Hospice.

L Rudge~ Interim Exec Director of Nursing from 8th Nov 2021 to 31st Dec 2021. Not a director of any other company.

D Sterling~ Non Exec Director - Not a Director of any other company. Trustee board of Bradford Diocesan Academies Trust**.** Board member for Race Equality Network.

R P Wilkinson ~ Non Exec Director **-** Director of a company that does not deal with public sector organisations**.** Independent member of the board and Trustee at Leeds Grand Theatre Opera House Ltd. NED Decipher Consulting UK Ltd.

N Senior ~ Associate Non Exec Director start date 15th Dec 2021. Not a director of any other company. Trustee Paladin NSAS Charity. Other Employment ~ Lead Health and Justice Commissioning Support at North of England Commissioning Support.

In 21/22 there were transactions between Calderdale & Huddersfield NHS Foundation Trust and related parties, additional to those declared under the scope of Whole of Government accounts, this include.

The Foundation Trust had expenditure with Pennine Property Partnership LLP in 2021/22 of £1,588,578 (20/21 £1,476,418) .

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