Public Board of Directors 13 January 2022 - Items for Board Assurance

Organiser Amber Fox

Documents for Review

1. Annual / Bi-Annual Reports

1. Charitable Funds Annual Report and Accounts 2020-2021

Calderdale and Huddersfield NHS Charity

Calderdale and Huddersfield NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS

For the year ended 31 March 2021

Helping our Trust do more

www.chftcharity.co.uk

Registered with FUNDRAISING REGULATOR
Charity Number: 1103694

compassionate care

1. Foreword and Chair's report

I am delighted to present Calderdale and Huddersfield NHS Charity Annual Report for 2020/21.

We can all agree that 2020/21 has been a year like no other, and despite the many challenges the outbreak of Covid-19 presented our Trust and our communities, I wish to express my sincere appreciation and thanks to our communities for supporting Calderdale and Huddersfield NHS Charity with such extraordinary generosity and donations.

Your donations, whether large or small, continue to make an enormous difference to our patients and staff every single day and as Chair I am amazed every year how our supporters respond with enthusiasm and drive to support us. We really do value each and every donation, no matter what the size.

It is challenging to capture the sheer intensity and volume of work our small charity team have undertaken this last year and I would like to thank everyone who has donated, fundraised and supported our team this year.

When I look back at our communities' kindness and compassion, I can see that children have undertaken their own fundraising challenges during lockdown, virtual events have taken place, you have baked, shaved your heads, ran many hundreds of miles, taken part in quizzes, ice bucket challenges – all the while helping us to do more for Calderdale and Huddersfield NHS Foundation Trust.

It is through the generosity of our donors and supporters that we have been able to increase the level of funding and support in 2020/21 and you will see in this report there are some examples of the great work our NHS Charity has undertaken and feedback from areas that have benefitted from our funding.

I would like to take this opportunity to also thank NHS Charities Together for supporting our organisation with grant funding early last year – and for everyone who rallied and supported the national Covid-19 Appeal.

I hope that you will enjoy reading this Annual Report and that, whatever role you play in being part of our NHS Charity now and in the future, you will agree that together we really can make a very big difference.

Thank you for your continued support,

Philip Lewer, Chair

2. WHO ARE WE

Calderdale and Huddersfield NHS Charity is a registered charity (registered number 1103694) in accordance with the Charities Act 2011 and was entered on the register on 18th March 2004.

The Charity raises money and receives donations for the benefit of the patients of Calderdale and Huddersfield NHS Foundation Trust. Donations given and money raised are for the purpose of funding projects, initiatives, equipment and improvements that are over and above what the NHS funds, enabling patients to access the best possible care and treatment possible.

Without the support of our fantastic fundraisers, donors and supporters we would not be able to support our NHS Trust colleagues enabling them to give patients and their families the level of care and support that they do.

Our mission is to support and fund initiatives beyond the remit and capacity of the NHS.

We believe

- Our patients should have the best possible experience we can provide
- Our buildings are accessible for all and equipped to suit the individual needs of our patients and visitors
- Supporting our NHS colleagues helps deliver outstanding compassionate care

Our values

Caring – we put our donors and beneficiaries at the centre of all we do, and by working together with CHFT we identify projects and initiatives that will enhance patient experience and outcomes, whilst supporting the health and wellbeing of the NHS.

Honest – we foster a culture where honesty, openness and transparency is encouraged and valued - managing expectations, doing what we say we'll do and treating others the way we want to be treated.

Fair – we are true to ourselves and others, valuing diversity, differences and recognising they make us stronger.

Transform - transforming lives is not just about the big changes, it's also the small acts of kindness that make a difference. Embracing change, challenging the status quo, celebrating success and learning from mistakes; we are always looking for new ways to innovate and improve.

Our objectives

- To improve patient experience
- To provide equipment, services and resources over and above NHS funding
- To support the health and wellbeing of NHS staff
- To provide the best donor experience we can and engage our communities in achieving our vision

Our social purpose is to support those that need us, when they need us, and to do so with integrity and pride.

3. OUR TEAM

3.1. CHARITY TRUSTEES

The Charity has a Corporate Trustee: Calderdale and Huddersfield NHS Foundation Trust governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011. The NHS Trust Board devolved responsibility for the on-going management of funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

The Executive Directors and Non-Executive Directors of the Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as Corporate Trustee in managing the Charity.

Members of the NHS Trust Board who served during the financial year ending 31 March 2021 were as follows:

Name	Title
Philip Lewer	Chairman
Owen Williams	Chief Executive
David Birkenhead	Medical Director
Gary Boothby	Director of Finance
Ellen Armistead	Director of Nursing / Deputy Chief Executive
Helen Barker	Chief Operating Officer
Suzanne Dunkley	Director of Workforce & Organisational Development
Alistair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Richard Hopkin	Non-Executive Director
Andy Nelson	Non-Executive Director
Denise Sterling	Non-Executive Director
Peter Wilkinson	Non-Executive Director

Non-Executive Members of the Trust Board are appointed by the Council of Governors whilst Executive members are subject to recruitment by the NHS Trust Board. Members are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

3.2. CHARITABLE FUND COMMITTEE

The Board Members of the Calderdale and Huddersfield NHS Foundation Trust as Corporate Trustee have devolved responsibility for the on-going management of the Charity to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

The Members of the Charitable Funds Committee in the financial year ending 31 March 2021 were as follows:

Name	Title
Philip Lewer	Chairman
David Birkenhead	Medical Director
Gary Boothby	Director of Finance
Ellen Armistead	Director of Nursing / Deputy Chief Executive
Richard Hopkin	Non-Executive Director
Peter Wilkinson	Non-Executive Director
Sheila Taylor	Council of Governors' Representative
John Gledhill	Council of Governors' Representative (Reserve)
Adele Roach	BAME Network Representative (from Nov 2020)

3.3 KEY PERSONNEL

Calderdale and Huddersfield NHS Charity team is made up of two members of staff, who manage all operations and activities the Charity undertakes.

Name	Title
Emma Kovaleski	Charity Manager
Carol Harrison	Charitable Funds Manager (finance)

Calderdale and Huddersfield NHS Charity

Calderdale and Huddersfield NHS Foundation Trust

4. OUR YEAR IN NUMBERS

£983,000 raised to help our Trust do more

3,400 new supporters

£377,000 spent on improving and enhancing patient experience and outcomes

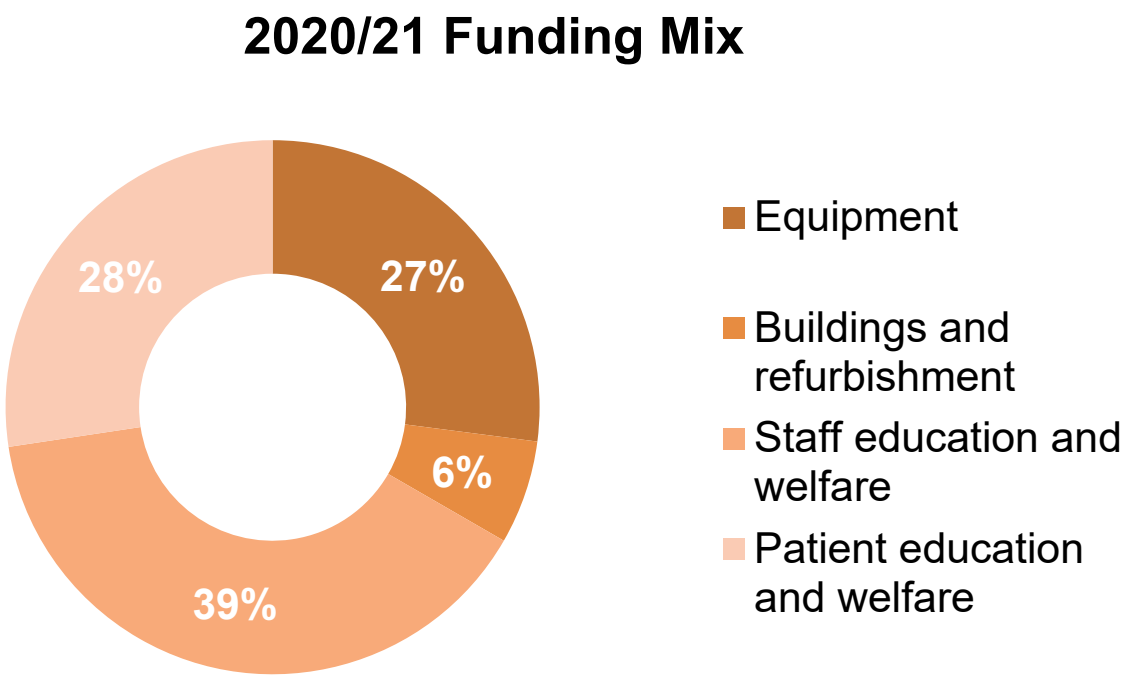
Thousands of donated gifts and products

700 volunteering hours

270 individual funding applications granted

£244,000 spent on supporting NHS colleagues

5. THE IMPACT OF OUR FUNDING – WHAT YOU HELPED US TO ACHIEVE



Calderdale and Huddersfield NHS Charity Funding Awarded

2020/21		
Funding priority	**Total**	**%**
Equipment	168,000	27
Buildings and refurbishment	39,000	6
Staff education and welfare	244,000	39
Patient education and welfare	170,000	28
Total (£)	**621,000**	**100**

This year, funding from Calderdale and Huddersfield NHS Charity has been awarded to over 270 single applications for charitable support. Applications for funding can be made by any Calderdale and Huddersfield NHS Foundation Trust employee, from any area of the Trust. Each application is categorised into one of our key funding areas:

- Equipment
- Buildings and refurbishment
- Staff education and welfare
- Patient education and welfare

The Charity assesses each funding application made against each of these four areas and where donations can have the most impact by providing the additional funding. Applications were welcomed throughout the year, and with an increased rate of funding applications to support staff education and welfare between March and July 2020, where we were required to provide immediate and urgent assistance and support to the Trust and NHS staff, due to the impact of Covid-19.

Across these following pages are examples of the great projects and initiatives, from each of our funding areas that we supported in 2020-21.

5.1. EQUIPMENT

Why giving back in support of Oncology services makes a difference.

Calderdale and Huddersfield NHS Charity invested £40,000 to fund 3 new Paxman Scalp Coolers for and on behalf of Calderdale and Huddersfield NHS Foundation Trust cancer patients.

Case study
In October 2019 Claire, a young mum of two small children began treatment for stage 3 breast cancer and during the following 10 months of aggressive treatment Claire was offered the opportunity to use one of the Trusts Paxman Scalp Coolers.

Claire said “I used to have really long blonde hair, but after my diagnosis I had my hair cut in to a bob. At one stage I even suggested shaving it off as I knew what I was going to be faced with – total hair loss.

However, I was offered the opportunity to try using the Paxman Scalp Cooler whilst receiving my treatment, and remarkably I barely lost any hair at all. 8 months, 8 rounds of chemotherapy and I kept my blond bob!

Cancer can set you apart from your friends, your family, your colleagues at work – I didn’t want that – especially at 32. And keeping my hair was so vitally important for my mental health and wellbeing, during treatment.

I was the first person to have cancer in my family, and my diagnosis was a complete shock, a bolt out of the blue. However the team at Calderdale and Huddersfield NHS Foundation Trust, every doctor, nurse, consultant, surgeon, domestic, porter – everyone, the whole team were incredible. They were exactly what I needed them to be for me, caring, supportive, and human. To care for me, listen to me, look after me, challenge me and support me. I cannot speak highly enough of everyone.

This was the hardest time of my life, and I have so much to be grateful for.

In October 2020, Claire began a gruelling 150 mile walk, as part of Breast Cancer Awareness month as a way to raise some much needed funds for Calderdale and Huddersfield NHS Charity as a way of giving back.

Claire raised over £2,200 and we are pleased and proud to say that Claire’s gift has contributed towards Calderdale and Huddersfield NHS Charity oncology funds, that have recently been used to purchase 3 new Paxman Scalp Coolers and support package.

Supporting Cardiology Patients

In August 2020 Calderdale and Huddersfield NHS Charity approved £32,580 to provide 50 new Mobile Echo Units for the Cardiology Team at Calderdale and Huddersfield NHS Foundation Trust.

Michelle Foster, Clinical Services Manager – Non-Invasive Cardiology commented that without funding provided by the Charity, the inpatient echo service at Calderdale and Huddersfield NHS Foundation Trust would have been adversely affected. This would lead to increased length of stay for patients and the inability to support the Angio/PCI service and the acute floor at the Trust.

With the new mobile units, we are able to provide our care on a patient’s ward – offering a more streamline and patient focussed service and leading to better patient experience. In addition to this, we are able to manage the outpatient echo service more effectively, as patients no longer have to return to an appointment at a later date.

“The generosity of Calderdale and Huddersfield NHS Charity, and its donors and supporters have ensured that we are able to keep delivering a fantastic level of care for our in-patients and continue to put quality compassionate care at the centre of all we do.”

5.2. BUILDINGS AND REFURBISHMENT

In December 2020 a new isolation ward was refurbished at Huddersfield Royal Infirmary, to care for the Trust's most fragile and poorly patients.

Calderdale and Huddersfield NHS Charity played a significant part in providing the all-important extras and finishing touches for patients and staff on the new ward.

The Charity approved an additional £8,500 to provide the finishing touches to the ward, such as a newly kitted out staff room and additional capacity to support virtual patient visiting.

Helen Hodgson, matron said "we now have a space that is welcoming, calming and scenic for patients who are cared for on ward 18. Every time I enter ward 18 I am amazed at how lovely the ward looks and feels. We really appreciate the kindness and generosity of our communities for donating funds to allow us to create such a wonderful space.

A special thank you to Mark Flynn Photography of Huddersfield for donating a range of images to display in the ward corridors and 15 side rooms, the images of local landscape and surroundings of Huddersfield really make a difference.

Supporting respiratory staff and patients

In Spring and Summer 2020 Calderdale and Huddersfield NHS Charity funded a range of added extras to support patients and staff on the respiratory ward at Calderdale Royal Hospital.

This funding supported the installation of a new water cooler, ice machine, the transformation of staff room facilities and the creation of a new 'wobble room'.

Nicola Clarke, respiratory ward sister said: "Covid-19 brought about so many challenges for staff and patients on the respiratory ward, and thanks to Calderdale and Huddersfield NHS Charity we were able to implement some long lasting improvements that helped us significantly through the peak of Covid-19 and continue to support us now.

The water cooler and ice machine are a dream come true, particularly when staff, donned in full PPE were unable to leave the ward for infection control reasons. Often hot, sweaty and dehydrated, the Charity funded equipment which enabled staff to keep themselves hydrated, without having to leave the area. This was not only a huge morale and wellbeing boost for colleagues, but also benefitted patients who were confined to CPAP (Continuous Positive Airways Pressure) masks and hoods, cared for pressurised rooms with no air flow.

The Charity funded the transformation of our staff room, with new dining facilities and lockers. It's a dedicated room for staff with a space too for personal messages of support, words of thanks from patients and their families and information about accessing wellbeing support.

Lastly funding and donations from our Charity helped to create our own wobble room, a special quiet room used to support the Health and Wellbeing of staff, or for the families of patients to use when they need quiet reflective time to themselves, often when receiving unfortunate news.

Calderdale and Huddersfield NHS Charity invested £7,066 to improve facilities on ward 5 at Calderdale Royal Hospital.

5.3. STAFF EDUCATION AND WELFARE

Supporting NHS Staff

Covid-19, and the mental health impact of the pandemic did not discriminate, and it affected everyone in some way.

Nikki Hosty, Assistant Director of HR, Workforce and Organisational Development Directorate said:

“As part of the on-going health and wellbeing support services offered to NHS staff at Calderdale and Huddersfield NHS Foundation Trust, it was recognised in the summer of 2020 that our front-line colleagues tackling the coronavirus crisis were routinely exposed to loss of patients, illness of colleagues, high levels of stress and increased exposure to Covid-19.

As a result of the impact, some of our colleagues could see a deterioration of their mental health or develop anxiety or the onset of Post-Traumatic Stress Disorder. We recognised that trauma needs should be dealt with early and effectively, so we approached Calderdale and Huddersfield NHS Charity to ask for funding to enlist psychological support as part of our colleague wellbeing package.

We are so grateful to the Charity, and because of the additional funding we received over 50 colleagues have accessed face to face 'life changing' psychological support which would not have been available without the support of our NHS Charity and its donors.”

In 2020/21 Calderdale and Huddersfield NHS Charity approved £10,000 to provide external support services via Socrates, Huddersfield.

Round the clock catering

As the nation entered lockdown in March 2020 and during the early stages of the pandemic, Calderdale and Huddersfield NHS Charity committed a significant amount of its additional funding raised, to providing additional, round the clock catering for NHS staff.

Gary Boothby, Executive Director of Finance said, “we wanted to provide for colleagues and ensure they were able to access a hot meal and refreshments, 24-7 – especially those working out of hours. Many ward based staff breakout areas were being repurposed to offer additional capacity for patients, so it was really important to the Executive Board and Incident Management Team at Calderdale and Huddersfield NHS Foundation Trust to make every adjustment we could to make sure staff needed to worry less about how they would be able to access a much needed break and nutritious food, particularly at a time where supermarkets were short and large queues were being experienced.”

Many colleagues were working additional hours to support our Covid-19 response to take care of our patients while looking out for one another, so opening the canteen areas offered a space for colleagues to distance away from their work area, take their much needed rest breaks and ensure they could maintain social distancing requirements.

After conducting a feedback assessment with colleagues here are some of the comments Calderdale and Huddersfield NHS Charity have received:

“The night shift meals have made a big difference as I do not have to bring food into the hospital reducing the risk of me taking the infection home.”

“Your funding has helped staff have a decent meal when our breaks have not been regular, when we have worked over night – it’s been great for staff health and morale.”

“It has been really nice to receive a hot meal and something on a weekend and night, not just during the week”

“You have helped staff get through their shifts.”

“Being able to get proper food & coffee on night shift has been a big help.”

“I can sleep longer when I am working nights, because I don't have to cook when I get home.”

“This helps so much, having one less thing to think about at a stressful time.”

“Most helpful when nothing else was open during lockdown.”

Calderdale and Huddersfield NHS Charity funded round the clock catering from the NHS Charities Together Stage 1 funding allocation. In 2020/21 the Charity spent a total of £142,000 on this provision.

5.4. PATIENT EDUCATION AND WELFARE

Bereavement and End of Life support for patients and their families

During 2020/21, it has been incredibly poignant to see the daily large numbers of families who lost loved ones, without being able to be by their side at the time of passing. Calderdale and Huddersfield NHS Charity committed to funding a number of initiatives, to ensure palliative/end of life patients and their relatives received additional support and care services, that pre-Covid-19 were not available.

End of Life Facilitator – specialist role

2020/21 was the second year Calderdale and Huddersfield NHS Foundation Trust funded the role and in this year Gillian Sykes, End of Life Facilitator has transformed the bereavement support services offered by Calderdale and Huddersfield NHS Foundation Trust. Gillian has been pivotal in setting up and managing a dedicated Bereavement telephone support service, for the families of loved ones who have passed away under the care of Calderdale and Huddersfield NHS Foundation Trust.

Gillian said “This service has really supported grieving families and friends who are feeling the sadness and loneliness of loss, with so many people having thanked us for contacting them, providing help with any questions and passing messages of thanks to ward teams and providing a caring and compassionate approach at such difficult times. I feel that the development of this vital service underpins the core values of Calderdale and Huddersfield NHS Foundation Trust and the staff who work within.”

The telephone service has opened up a two way conversation with families, something which we have not had before. The calls not only show we are thinking of the family, but we are wanting to hear feedback, hear suggestions and address change and continue to improve.

Feedback from calls is shared with relevant colleagues, such as Matrons, Ward Sisters and Consultants.

Funding has also contributed towards bereavement boxes, small personalised boxes that are sent to a bereaved family, offering condolences, support and signposting to local bereavement support services. Feedback from families has been beyond incredible, and testament to the innovation, adaptation and compassion of Calderdale and Huddersfield NHS Foundation Trust and its workforce.

Recent relative feedback can be read below:

- Heartfelt thanks for the card and heart, I loved that the card was handwritten as it made it more special, and that Mr B also had a heart.
- I slept with the heart the day it was received and had it with me when I did the eulogy. I am going to put the seeds on his grave.
- I can’t describe the feeling when we got the box. Totally overwhelmed and speechless. Made us feel so connected and close to A – we were happy knowing he had a heart too.
- As an employee of the Trust and someone with personal experience of dealing with the sadness of Covid-19, I would like to say, we are getting it right. My family found the bereavement box, containing a heart, some marigold flower seeds and a heart-warming message from the Trust comforting.
- It’s beyond words how much we appreciated the box and your call today. Thank you so much.

Marigold Bags. The Charity funded high quality, branded cotton bags, to be used to hand a patients personal possessions and belongings over to their loved ones following their death.

In 2020/21 Calderdale and Huddersfield NHS Charity invested £44,957 in Bereavement and End of Life services.

Meet Aspen.

Aspen is a life like, weighted new born baby doll, purchased using donations to Calderdale and Huddersfield NHS Charity.

Aspen forms part of the care and support provided by Nicola Ingle, the Trusts Early Intervention Midwife.

Nicola said “Aspen is such a wonderful addition to our team and has already transformed the level of support we are able to provide expectant parents, who have learning disabilities or additional needs.

We are now able to offer hands on, practical support in the basic care needs of a newly born baby, as well as addressing concerns around cot death, newborn examinations, bonding and attachment issues.

Aspen has empowered many patients to talk about their concerns in becoming new parents, and having Aspen as part of the team helps to address these concerns, to build confidence, knowledge and understanding.

Aspen’s funding goes to show that it is not always the higher value investments made by the Charity which have a demonstrable impact. £82 of the charities’ funding was used to purchase the doll.

Providing wigs for cancer patients

“I used to have long hair before I started to lose it all when receiving treatment for cancer. My self-esteem and confidence were non-existent after being diagnosed with cancer and unfortunately losing all of my hair affected me mentally and emotionally.

However, thank you to the team in the cancer centre at Calderdale Royal Hospital and Calderdale and Huddersfield NHS Charity I was provided with a high quality wig, which was truly amazing. The level of service was outstanding and all of my needs were looked after and I received a wig that that was so much like my original style and colour. The quality is outstanding.

I really hope for other women and men that this service makes such a difference too, as you are giving people with cancer a chance to still feel as normal as possible, supporting patients’ health and wellbeing while going through treatment and after treatment.

There are no words to express how grateful I was and I cannot thank the Charity enough.” Tracey Thackray, patient.

Helen Jones, Macmillan Information Centre Manager, at Calderdale and Huddersfield NHS Foundation Trust said “It makes me feel really proud that the Charity see funding wigs for cancer patients as a priority, I get to see first-hand the difference a high quality wig makes to a patient, in helping increase the patient’s confidence, body image and wellbeing. Thank you to everyone for their continued support in helping to make a difference.”

In 2020/21 Calderdale and Huddersfield NHS Charity funded £7,378 on wigs for cancer patients.

5.5. COVID-19

During 2020/21 Calderdale and Huddersfield NHS Charity funded and sourced a large range of items, mobilised access to training and support services, funded wellbeing projects and initiatives and those all-important added extras that were needed as a time when our communities, our patients and our colleagues faced the most challenging of circumstances.

The Charity committed to supporting Calderdale and Huddersfield NHS Foundation Trust whenever and where-ever it was required, and reflecting back upon the year and reviewing the range of items, projects and initiatives the Charity have funded is quite staggering from tablet stands, to make sure elderly patients can still speak with their family and loved ones on an electronic tablet, without having a member of the nursing team sat by their side to hold the device for them, to funding virtual choir sessions to boost staff morale, coffee machines, televisions and fridges, items for listening events and debrief sessions, pilot gym sessions for cardiac rehab patients, stroke connection software, Muslim prayer beads and bravery awards for our youngest of patients.

2020/21 has been a year like no other, and we cannot thank our communities enough for supporting us, donating to us, being there for us and alongside us, while we have supported patients and NHS colleagues in so many ways.

6. OUR AMAZING SUPPORTERS

At Calderdale and Huddersfield NHS Charity, we are incredibly grateful to our donors, fundraisers and volunteers who have been there for us, and supported in so many wonderful ways.

In 2020/21 we welcomed over 3,400 new supporters and in doing so increased the Charity income by an incredible £547,000 compared with 2019/20.

Amount raised during 2020/21				
Activities for generating funds	**Unrestricted**	**Restricted**	**Total**	**%**
Donations	663,000	136,000	799,000	81
NHS Charities Together Covid-19 Appeal grants	-	144,000	144,000	15
Legacies	36,000	-	36,000	4
Total (£)	**699,000**	**280,000**	**979,000**	**100**

The table above shows our main sources of income this year, with our largest source of income being generated from our wonderful communities of donors and supporters, in response to the Covid-19 pandemic and the national drive to support NHS Charities.

At all times our charity prioritises the needs and wellbeing of our supporters, donors and beneficiaries. Our supporters and donors are our greatest strength, and without whom we would not be able to make such a difference and fund the projects and initiatives that we have, and continue to do so.

Our Fundraising Promise aligns with the Code of Fundraising Practice and the Charity's social purpose to support those that need us, when they need us, and to do so with integrity and pride. A copy can be found on the Charity website.

The Fundraising team provides guidance, information, support and training wherever possible to ensure our fundraisers and volunteers have a rewarding experience and carry out their fundraising activities in a way that is legal, open, honest and respectful.

Supporters fundraising 'in aid of' Calderdale and Huddersfield NHS Charity are encouraged to register with the Fundraising team, where they will be given guidance and asked to sign a Fundraising Agreement, where appropriate. A letter of authority is also issued as required.

By signing up to fundraise in aid of Calderdale and Huddersfield NHS Charity, supporters agree to comply with our policy as well as the Fundraising Regulator's Code of Fundraising Practice. Wherever possible the Charity undertakes monitoring to ensure compliance. This includes regular contact with known supporters and reviewing fundraising materials published citing Calderdale and Huddersfield NHS Charity as the beneficiary of fundraising activities.

Calderdale and Huddersfield NHS Charity is proud to be registered with the Fundraising Regulator and received no complaints through this regulatory body in 2020/21.

6.1. COMMUNITY FUNDRAISING

Throughout the year Calderdale and Huddersfield NHS Charity has been supported by hundreds of community fundraisers, in the main helping to raise money for Calderdale and Huddersfield NHS Charity in aid of the Thank You CHFT Covid-19 campaign.

Our supporters and donors are our greatest strength, without whom we would not have been in a position to support Calderdale and Huddersfield NHS Foundation Trust in the ways we have during 2020/21.

From virtual events, head shaves, lockdown schools fundraising, to running, riding and walking thousands of miles, our communities across Huddersfield and Calderdale have been beyond incredible, and we cannot thank each and every person enough for all they have done for and on behalf of us.

Here is a snapshot of some of our incredible community fundraisers.

Inspired by Captain Tom, Stephen Collins set about his own charity challenge. Stephen, who suffers from Cerebral Palsy, walked for 61 consecutive days, in celebration of his 61st birthday in April 2020 – each walk a lap of his residential street. The final walk took place in July 2020, when Stephen completed a gruelling uphill hike to Huddersfield Royal infirmary, where he was welcomed by the team of nurses and physiotherapists who supported and cared for Stephen after a fall in 2019, where he broke his leg in two places. Stephen raised over £2,700.

Local running club, Northowram Runners ran over 5,000 miles and raised over £7,700 in just 30 days as part of their virtual rainbow challenge.

DJ Biggles from Slaithwaite ran a series of Facebook live DJ events during the summer of 2020, raising over £3,368.

Over £700 was raised across Lightcliffe, through a family fun trail – for local residents to take part during their one hour daily exercise.

Jordan Powell raised funds to support the health and wellbeing of colleagues at Calderdale and Huddersfield NHS Foundation Trust by undertaking a 10,000 burpee challenge – and raised over £2,700.

Postal workers in Holmfirth undertook their deliveries in fancy dress and raised over £700.

Local artist Roger Davies raffled a piece of his artwork raising £3,000.

Children from Year 1 at Salterhebble Primary School, Halifax undertook their own ice bucket challenge, hoping to raise £60, the year group raised a wonderful £1,223 – 2037% of their target.

Local resident Mark Holden organised a 24-hour bowl a thon at Elland Bowling Club, raising over £2,500.

A spotlight on Sam Higginbottom.

Induced into a coma in January 2020 and diagnosed with MRSA PVL, double pneumonia, and sepsis, Sam Higginbottom spent the following 3 months in the Intensive Care unit and Respiratory ward at Calderdale and Huddersfield NHS Foundation Trust where, although he was making a steady recovery, suffered from long term lung damage and nerve damage to his back & legs.

Once home in April, Sam began his rehabilitation and made significant steps to aid his recovery and as part of this committed to training for a marathon in December 2020.

Sam said “I feel the best way to give back and make the biggest impact to the people who kept me alive is to raise as much money as possible for Calderdale and Huddersfield NHS Charity to ensure the hospitals have everything they need to be able to help others and save more lives.”

Sam completed the 26.2 mile run in December 2020, in terrible conditions and was welcomed to Huddersfield Royal Infirmary by his family, friends and members of staff from the hospital’s Intensive Care Unit.

Sam’s incredible story, his recovery and dedication to giving back, raised Calderdale and Huddersfield NHS Charity an incredible £6,700.

In Memory

Donations in memory of loved ones were very gratefully received by Calderdale and Huddersfield NHS Charity and during 2020/21 over £43,000 was kindly donated to the Charity in memory or in lieu of funeral flowers.

We are so incredibly grateful for all donations received.

6.2. CORPORATE SUPPORTERS

Throughout 2020/21 Calderdale and Huddersfield NHS Charity have been overwhelmed with the support that we received from corporate supporters in response to the Covid-19 pandemic. We have received thousands of 'Gift in Kind' donations from businesses across Yorkshire and beyond. This included toiletries, electronics, food and refreshments for staff and accommodation.

Here are some of the businesses we would like to extend a special thank you to:

- CHS Ltd
- Zoflora
- Wayfair/GNG
- Childs Farm
- Mamas & Papas
- KC Communications
- Bewleys
- Thornton and Ross
- Furniture123
- Towndoor
- Dugdale
- Zest For Print
- Mark Flynn Photography
- Neom
- Nestle
- FMG Ltd
- Yorkshire Soap Company
- The Piece Hall, Halifax
- Harveys of Halifax
- Halifax Town FC

We would like to say a huge thank you to all our corporate supporters who have helped to raise funds and donate products and services for patients and staff at Calderdale and Huddersfield NHS Foundation Trust. In total our corporate supporters in 2020/21 raised £603,000.

Spotlight on CHS Ltd

Stuart Sugarman Managing Director of Calderdale and Huddersfield Solutions Limited (the wholly owned subsidiary company that delivers estates, facilities, medical engineering & devices training and procurement service to Calderdale and Huddersfield Foundation Trust) delighted us when he announced that CHS would be donating £500,000 to Calderdale and Huddersfield NHS Charity in support of its charitable objectives.

Stuart said "CHS is a socially responsible company so it was a pleasure to make this donation to such a great cause as we really want to support our Trust and its fabulous charity."

Charity Manager, Emma Kovaleski, stated, "I think it goes without saying how incredibly moved I was upon hearing the news that CHS have been in a position to support our NHS Charity with such an incredible gift! I know just how much this will contribute to supporting our aims and objectives - providing our patients, colleagues and communities with the very best care and experience possible."

Spotlight on KCC Communications

We were thrilled to have supported the Calderdale and Huddersfield NHS Foundation Trust throughout the pandemic, including supporting the promotion of the Thank You CHFT campaign and providing social media support for fundraising initiatives. The Trust plays such an important role within our local community, so we

were so pleased that we could help the Charity team raise awareness of the amazing work that is done and celebrate the heroes of the last 18 months. Ellis Noble, Account Director

Spotlight on ChildsFarm

As a skincare company, we were proud to donate products to the Thank you CHFT campaign and support staff in the way we know best – by ensuring our amazing healthcare workers are keeping themselves safe and healthy during such a busy time.

They are putting strangers first every day and night they are working. We can't do much, but if we can bring a smile because hands are less sore, or even to show they are not forgotten, we will. Heather Starke, PA to Founder.

Spotlight on Community Partnerships – thanks to Calderdale Community Foundation

How our communities brought the joy of Christmas to CHFT!

For many years during December we have welcomed donors and communities into our hospitals at Calderdale and Huddersfield NHS Foundation Trust (CHFT) to share cheer and raise festive spirits but due to Covid-19 restrictions we had to approach the 2020 festive season a little differently.

Calderdale and Huddersfield NHS Charity launched their first Christmas Gift Appeal in October 2020 offering our communities the opportunity to support our Trust by providing a gift or token of appreciation. Emma Kovaleski, Charity Manager said

"It was really important to us to add a little festive sparkle, particularly this year when we faced so many challenges and restrictions due to Covid-19, and following conversations with our colleagues at CHFT we launched what we hoped was going to be a hugely successful first Christmas appeal.

Our charity offices very quickly turned into Santa's Grotto over the Christmas season as hundreds of local residents stepped forwards supporting our Amazon Wish List via the appeal".

The Amazon Wish List was created to provide toys, activity packs and books for our younger patients who found themselves in hospital over the Christmas period.

Danielle Brook from our Play Therapy team said:

"The gift appeal was amazing, thank you to everyone for all their hard work. Giving gifts through the wish list meant we as a play team were able to focus on our patients and their families during our busiest time of year, safe in the knowledge that we were still able to keep the magic of Christmas alive because of our NHS Charity and donors".

Realising the success of the Wishlist, our NHS Charity reached out to community organisations with another special request, to provide our most frail patients with a special gift also.

Steve Nicol, from Halifax Town Community Foundation was pivotal in mobilising a partnership with Halifax based organisations and businesses, who very quickly came together to help support the Charity's call. Steve said:

"FC Halifax Town Foundation, the charitable arm of the club are working in partnership with our local NHS Charity. We wanted to show our appreciation for NHS staff who have faced an extremely challenging year, support patients hospitalised over the festive period and really show the spirit and togetherness of our community".

Calderdale Community Foundation, unlocked funding from the Halifax Courier Fund to help support our most vulnerable patients. The funding provided over 300 unique gifts for our most frail patients and were provided by Harveys of Halifax and businesses at The Piece Hall. Steve Duncan, CEO of Calderdale Community Foundation said:

“It was really important for our organisation to support the appeal, but also support local retailers by providing the funds locally”.

On behalf of patients Helen Hodgson, Matron, Acute Medicine said:

“Thank you for the absolutely amazing and very generous gifts and for all who donated and supported our Christmas appeal you have given something very special indeed”.

6.3. CHARITABLE TRUSTS

Once again, throughout 2020/21 Calderdale and Huddersfield NHS Charity was fortunate to be supported by a range of charitable trusts.

We would like to extend our thanks to everyone who has helped the Charity throughout the last year, particularly:

The Nick Smith Foundation

Working alongside Calderdale and Huddersfield NHS Charity, the Nick Smith Foundation have jointly funded a new MND Care Coordinator post at Calderdale and Huddersfield NHS Foundation Trust.

The Nick Smith Foundation is donating a total of £16,200 (matched by Calderdale and Huddersfield NHS Charity) to fund the 2 day per week role.

The new role is the first for the Trust and aims to provide patients with a single point of contact, ensuring a joined-up approach to care and signposting extra support for those diagnosed and their families.

Beth Macdonald was appointed into role in 2020, and said:

“I am very excited to be in the role and am hoping to make great improvements in the experiences of people with Motor Neurone Disease, and their families.

“I have worked in the community as an Occupational Therapist for many years, working closely with people with Motor Neurone Disease and their families. This has enabled me to see where hospital and community services and support could be improved locally and delivered in a way that offers people a more coordinated and supportive approach as they navigate life with this very difficult condition.

“I am optimistic that the coordinator role will have a significant positive impact on the health and wellbeing of people with MND in the Calderdale and Huddersfield NHS Trust area.”

NHS Charities Together

Calderdale and Huddersfield NHS Charity would like to thank every donor who came forward and supported NHS Charities Together national Covid-19 campaign during 2020/21. Calderdale and Huddersfield NHS Charity have received several grants from ‘NHS Charities Together’ totalling £179,000, £144,000 of which was during 2020/21.

The grants received have helped Calderdale and Huddersfield NHS Foundation Trust (CHFT) and their NHS Charity to support colleagues and patients in a variety of ways during the Covid-19 pandemic.

The funds granted during 2020/21 have been utilised in a variety of ways, such as:

- Provide psychotherapy external support to NHS staff
- Provision of 24 hour catering at both Calderdale Royal Hospital and Huddersfield Royal Infirmary during the first wave of Covid-19
- Distribution of over 150 wellbeing boxes to priority areas across both hospitals and in the community sites
- Equipping a range of wobble rooms and breakout facilities for staff
- Recruitment of the Trust’s first BAME Community Engagement Partner
- Increased capacity and resources to support virtual patient visiting and digital transformation

6.4. LEGACIES

We are incredibly grateful for the heartfelt support we receive from individuals who have very kindly made provisions in their Wills for Calderdale and Huddersfield NHS Charity.

In 2020/21, legacy income amounted to £36,000. We are truly grateful for the support we receive.

6.5. OUR VOLUNTEERS

Charity volunteering at Calderdale and Huddersfield NHS Charity began in earnest during 2020/21, as the Charity recruited their first fundraising support volunteer, to help the Charity in welcoming and managing the large scale outpouring of support and donations, as part of the response of our communities to Covid-19.

Over the course of 2020/21 Helen Chadwick-Hamilton dedicated over 700 volunteer hours to the Charity working full time during the months of March to July, and was an integral part of the charity fundraising team.

Calderdale and Huddersfield NHS Charity would like to extend this opportunity to thank Helen for all she has helped the charity achieve during this time.

Over the next 12 months we hope to grow the number of volunteers in varied roles across all hospital sites, working with and complementing the fantastic work the Trust Volunteer Services team are doing.

We will work hard to diversify and promote the opportunities we can offer to volunteers and build strong and lasting relationships with new communities.

We also plan to recruit new volunteers and volunteer fundraising groups to support at the Charity events, its campaigns and growth in community fundraising activity and income.

6.6. GIFTS IN KIND

During 2020/21, and through the outpouring of support, affection and generosity in response to Covid-19 and the impact of the pandemic, Calderdale and Huddersfield would like to express its sincere appreciation to every one of the thousands of donors and supporters who made a gift to the Charity.

All gifts donated to the Charity during the year have been shared or utilised by Calderdale and Huddersfield NHS Foundation Trust staff, during the same period.

See note 1 (e) for a review of how Gift in Kind donations have been accounted for in 2020/21.

7. GOVERNANCE

7.1. ROLE AND RESPONSIBILITIES

The Charity has a Corporate Trustee: Calderdale and Huddersfield NHS Foundation Trust NHS Foundation Trust, governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Acts 2011. The NHS Trust Board devolved responsibility for the on-going management of funds to the Charitable Funds Committee which administers the funds on behalf of the Corporate Trustee.

The Executive Directors and Non-Executive Directors of the Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as Corporate Trustee in managing the Charity.

Non-Executive Members of the Trust Board are appointed by the Council of Governors whilst Executive members are subject to recruitment by the NHS Trust Board. Members are not individual trustees under Charity Law but act as agents on behalf of the Corporate Trustee.

As Trustees, all are required to ensure that:

- the income of the Charity is applied with complete fairness between the persons who are properly qualified to benefit from it,
- they act reasonably and prudently regarding any decisions made in respect of the Charity,
- they exercise the same degree of care in dealing with the administration of the funds as that of a prudent business person would exercise in managing his or her own affairs or those of someone else for whom he or she was responsible,
- they are able to demonstrate that its charitable aims are for the public benefit.

The Charitable Funds Committee is required to:

- Ensure that Charitable Fund expenditure is approved in line with the Trust's Scheme of Delegation and Standing Financial Instructions,
- Update and maintain Charitable Fund policies and procedures in accordance with Charity Commission guidance,
- Receive and review regular reports on Charitable Fund income and expenditure and on the investment of the Charity's funds,
- Ensure that the Trust's Charitable Funds are established and operated in accordance with relevant law,
- Approve the establishment of new designated funds on behalf of the Corporate Trustee,
- Ensure that audited accounts are completed, submitted to the Charity Commission and made available to the public,
- Ensure that policies and procedures are in place, which are in line with the Trust's Standing Financial Instructions and best practice elsewhere, to manage the investment of the Charity's funds,
- Support the development and growth of the Charity,
- Review and develop the Charitable Funds' Strategy.

7.2. COMPLIANCE

Calderdale and Huddersfield NHS Charity complies with the provisions of the Data Protection Act (2018) and the General Data Protection Regulations (2018) in so far as they apply to the operations of the Charity. There is a Privacy Policy in place which is available on the Charity website. During 2020/21 there were no reported breaches. Calderdale and Huddersfield NHS Charity additionally is registered and complies with the Code of Fundraising Practice.

7.3. RISK MANAGEMENT

The Corporate Trustee is responsible for:

- Keeping complete and up to date accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust, to enable it to ensure that the accounts comply with requirements in the Charities Act 2011,
- Establishing and monitoring a system of internal control,
- Establishing arrangements for the prevention and detection of fraud and corruption.

Internal risks are minimised by the implementation of procedures and systems, which are designed to provide assurance against misstatement or loss and are reviewed periodically. They include:

- Delegation of authority and segregation of duties,
- Authorisation of all transactions and projects,
- Identification and management of risks,
- Regular reports by Audit Yorkshire (which provides an Internal Audit function).

Principal Risks:

- Fall in income from donations,
- Fall in investment market value.

The Charity has a Risk Register which records strategic and operational risks. Every risk is assessed against a matrix which measures likelihood and impact, both before and after mitigations have been applied, and a target risk score. Risks are added as they are identified and archived once they have reached their target score for a given period.

7.4. COMPLAINTS

A Complaints policy is not yet in place and forms part of the 2021/22 plans for the Charity development. However details about how to contact the Charity to make a complaint, alongside details of the Charity Commission and Fundraising Regulator can be found on the Charity website. During 2020/21 the Charity did not receive any complaints.

7.5. CHARITY SECTOR GOVERNANCE AND PARTNERSHIPS

The Charity is regulated by the Charity Commission and is a member of the Fundraising Regulator, the self-regulatory scheme for fundraising in the UK. By being a member of the Fundraising Regulator the Charity has committed to its principles which are:

- We are committed to high standards
- We are honest and open
- We are clear
- We are respectful
- We are fair and reasonable
- We are accountable

The Charity has also documented a Fundraising Promise which can be found on the Charity website and is in line with the Charity values of being **Caring**, **Honest**, **Fair** and to **Transform**.

In addition, Calderdale and Huddersfield NHS Charity is one of over 240 NHS charities in England and Wales who are eligible to join the NHS Charities Together. As a member charity we have the opportunity to benchmark our fundraising activity with our peers, discuss matters of common concern and exchange

information and experiences and to participate in conferences and seminars which offer support and education for our staff and trustees.

We utilise other bodies and publications in the third sector to benchmark ourselves including the Chartered Institute of Fundraising, Charity Commission and the Third Sector and Charity Today.

8. GOVERNANCE REVIEW

During 2020/21 the Charity made the decision to pause its operational and governance review, as it focussed on supporting Calderdale and Huddersfield NHS Foundation Trust through the Covid-19 pandemic peaks.

However progress has been made during this period in a number of areas, highlighted below:

8.1. OUR COMMITTEES

The Corporate Trustee designated responsibility for the overall strategic and governance of the Charity to the Charitable Funds Committee, The Charitable Funds Committee meets four times a year to ensure the proper management of funds, and these are spent in accordance with the wishes of the donor and the Objects of Calderdale and Huddersfield NHS Charity.

As part of a review of governance, skills and diversity of the Charitable Funds Committee, it was recognised that the Charitable Funds Committee did not have representation from the Trust's BAME Network and therefore, in November 2020, following engagement with BAME network members, Adele Roach joined the Charitable Fund Committee.

As part of this process, the Charitable Funds Committee also established an Operations Sub Committee. The Operations Sub Committee and Charitable Funds Committee have agreed Terms of Reference, appointing Operations Sub Committee members with appropriate skills, experience and representation from Calderdale and Huddersfield NHS Foundation Trust.

The main objective of the Committee is to support the development and progress of fundraising and to make recommendations to the Charitable Funds Committee whether general purpose funding applications should be approved.

8.2. PUBLIC BENEFIT

The Corporate Trustee has a duty to comply with Section 17 of the Charities Act 2011 which outlines the Charity Commission's general guidance on public benefit. The Trustee confirms that this requirement is strongly embedded within the procedures for approving funding applications and spending plans and that Calderdale and Huddersfield NHS Charity has fulfilled the public benefit requirement.

As part of operational management the Trustee, Charitable Funds Committee, Operations Sub Committee and Charity Management team ensure that all funding applications and spending plans contain identifiable public benefits that are clear and meet the charitable objects of Calderdale and Huddersfield NHS Charity by supporting any NHS charitable purpose relating to Calderdale and Huddersfield NHS Foundation Trust and its patients. Calderdale and Huddersfield NHS Charity's strategic goals and the public benefit requirement are satisfied through funding a range of projects, examples of which can be found listed elsewhere in this Report under each of our priority areas.

8.3. RESERVES POLICY

The Charity reviewed and agreed a new Reserves Policy in February 2021 which applies to restricted and unrestricted funds. The Reserves Policy will be reviewed annually by the Charitable Funds Committee. Further detail can be found in section 9.4.

8.4. MOVING FORWARDS – HOW DO WE IMPROVE?

Governance review
One of the principles of good governance is to review an organisation on a regular basis against a benchmark. For Calderdale and Huddersfield NHS Charity the appropriate benchmark is the Charity Governance Code and Fundraising Regulator Code of Conduct. A full review against both Codes will be undertaken as part of the next phase of the Charity development and 2 year strategy (2021-2023). Whilst the current governance

of Calderdale and Huddersfield NHS Charity meets the requirements of the Code in the majority of areas there are a few in which improvements need to be made as part of the continuing development and improvement of the Charity. Following the review an Action Plan will be drawn up to ensure that the issues which were identified are addressed.

Areas of focus will be as follows:

- revision of policies (including Privacy and Data Handling Ethics, Conflict of Interest and Reserves),
- creation of new operational documentation (including commercial participators' agreement)
- measures to increase the diversity of the Operations Sub Committee,
- revision of the risk management process
- the introduction of a new charity operations, fundraising and finance database system.

Many of these requirements have either been completed or are moving towards completion and it is anticipated that this will be achieved in 2021-22. The Corporate Trustee and Charitable Funds Committee will receive regular reports on progress.

Raising Brand awareness
A major part of the ability of charities to raise funding from donors, of whatever type, is awareness of the existence of the Charity, what it raises funding for and how it has applied donations in the past. Calderdale and Huddersfield NHS Charity considers that there is potential to improve awareness of the Charity across both the communities of Calderdale and Huddersfield and across Calderdale and Huddersfield NHS Foundation Trust estate, including colleague engagement. Focussing activities in this way will extend the supporter base and ability to fund projects in support of the charitable objects. Significant effort will be made to improve brand awareness during 2021-22 and it is expected that this will be reflected in more enduring unrestricted funding being available both in that year and into the future.

Working with Fund Managers
It is important to develop a greater awareness of the Charity within Calderdale and Huddersfield NHS Foundation Trust, as well as improving understanding about how to access the available funds, partly through increased engagement with existing Fund Managers. The direction of travel in 2021-22 and beyond will be to grow unrestricted funding and increase equality of opportunity for all areas within the Trust to access this funding. Part of the approach will be to involve a growing number of Trust and other external advisers in the Operations Sub Committee which recommend those applications to be funded.

Evidencing public benefit and outcome reporting
Operational changes and new procedures, including a new Guide to Accessing Charitable Funds for all staff, including Fund Managers will support the Charity and the Corporate Trustee in evidencing public benefit, as per the Charity Commission's guidance.

Contained within the Guide are recommendations and requirements for all staff (including Fund Managers) to consider and assess public benefit, public perception and additionality tests as part of each individual funding application, regardless of the level of funds being applied for. The document also contains a newly developed scoring matrix – to assess the public benefit of funding applications made to the general funds.

Evidencing public benefit through impact and outcome reporting becomes a mandatory requirement, through the launch of new Charitable Funding Terms and Conditions.

Team development
During late 2020/21 the Charity undertook a capacity and skills audit and recognised the need to increase the size of the Charity team and its sector knowledge, skills and experience to aid and support the plans for future growth and development.

During 2021/22 the Charity will recruit the following two positions on a two year fixed term basis:

- Charity Fundraising and Engagement Coordinator

- Communications and Marketing Assistant

It is anticipated the new team will be recruited and in place by the end of 2021.

Equality, Diversity & Inclusion
Calderdale and Huddersfield NHS Foundation Trust aim to develop an environment where people understand and respect each other's differences, a place where you can be what you want to be, a place where colleagues work hand-in-hand with one another to deliver one culture of care, Calderdale and Huddersfield NHS Charity is no different.

The Charity recognises that difference brings strength and is to be celebrated. Forming part of the 2021-23 strategy the Charity will continue its journey to demonstrate its commitment to equality, diversity, and inclusion by fostering a closer working relationship with the varying networks at Calderdale and Huddersfield NHS Foundation Trust, whilst exploring how the Charity can position itself to support the networks and patients and communities the Trust care for.

The Equality Networks give Trust colleagues the opportunity to share and highlight areas where we need to improve at Calderdale and Huddersfield NHS Foundation Trust, whilst being a vital link and voice for our diverse communities across Calderdale and Huddersfield.

A subset of this piece of work will be to actively champion and support Calderdale and Huddersfield NHS Foundation Trust in addressing and tackling health inequalities for and on behalf of our patients, colleagues and communities we serve.

9. FINANCIAL REVIEW

9.1. INCOME

In 2020/21 the total incoming resources amounted to £983,000. This is an increase of £547,000 on the previous year's balance; this was due an increase in donations (£595,000), partly offset by a decrease in legacies (£37,000) and other income (£11,000).

The total income received by the Charity exceeded the expenditure this year by £289,000. In addition, there was a positive movement of £538,000 arising from the revaluation of investment assets. As such, there was an overall increase in the funds of £827,000 to £3,200,000.

9.2. EXPENDITURE

In 2020/21 the Charity spent £621,000 on charitable activities; this includes an allocation of the support costs that the Charity incurred in the administration of the fund of £38,000 comprising costs for Financial Services support, External and Internal Audit and other establishment costs which include online giving fees and printing and stationery costs.

The Charity also incurred costs of £58,000 in raising funds.

9.3. GOING CONCERN

The accounts have been prepared on a going concern basis. At the end of the financial year Calderdale and Huddersfield NHS Charity had total net assets in excess of £3.2 million. The Covid-19 pandemic has had an impact on the Charity's fundraising income for unrestricted funds although this is partially offset by the generous donations made by members of the public in the first lockdown and restricted income from the NHS Charities Together national appeal.

The value of the Calderdale and Huddersfield NHS Charity investment portfolio rallied as global markets experienced a steep recovery in quarter one following the lows experienced at the onset of the Covid-19 pandemic. The Trustees have reviewed the Charity's commitment for the next 12 months and are confident that there are sufficient unrestricted free reserves to meet its commitments as they fall due. The Charity maintains an adequate cash position to meet its on-going expenditure requirements. The Corporate Trustee considers that there are no material uncertainties about the Charity's ability to continue as a going concern.

9.4. RESERVES POLICY

The Corporate Trustee has a legal duty to apply charitable funds within a reasonable time of their receipt but should also hold some money in reserve. Within our Charity we therefore have three funds which form our reserves – the two General Purpose funds and the General Reserves fund. The balances on these, less any commitments, form the total of the Charity's Reserves.

The Corporate Trustee encourages the use of balances and intends that designated funds are spent within a reasonable period of receipt and therefore expects to only maintain a minimum reserve balance to allow the charity to remain operational and to mitigate unforeseen circumstances.

It is necessary to retain reserves over the longer term to:

- Reduce the impact of risks should the levels of income (including fluctuations in the value of investments) reduce significantly such that the Charity cannot meet its obligations.
- Ensure the Charity can cover its on-going operational costs – these include governance costs such as salaries and audit fees and also fundraising costs.
- Meet the closure or transfer of the Charity's affairs should the need arise.

The Reserves Policy (February 2021) states *The Corporate Trustee aims to retain, as a minimum, a level of reserves sufficient to provide funding for* ***three months' operational costs*** *(including governance and fundraising costs).*

9.5. INVESTMENT POLICY AND PERFORMANCE

All investments are made in accordance with guidance issued by the Charity Commission; the Charity's investment manager is CCLA Investment Management Ltd.

The Charity seeks to balance ethical and socially responsible investment and risk. As such, the investment managers appointed by the Charity are restricted from investing directly in the processing and/or manufacture of tobacco products, and the portfolio of investment is widely diversified.

The investment objective is to provide a balance between long term capital growth, security, availability and maximisation of annual income.

At 31 March 2021 the market value of investments managed by the Charity's investment manager, CCLA Investment Management Ltd was £2,636,000 compared to £2,238,000 at 31 March 2020.

During the financial year 2020/21, Calderdale and Huddersfield NHS Foundation Trust Charitable Funds made a £538,000 unrealised gain on investment assets; this is compared to an unrealised gain experienced in 2019/20 of £18,000. It should be noted that the Charity liquidated investments to the value of £140,000 in 2020/21.

10. PLANS FOR THE FUTURE

2020/21 was the year for NHS Charities nationally and locally, and following a year like no other Calderdale and Huddersfield NHS Charity are now taking the opportunity to review operations, develop a longer term strategy and a plan for the continuation and growth across all its activities.

Following on from an incredible year of raising more income than in previous years, funding more projects and initiatives to enhance patient care and support the NHS and significantly raising the Charity profile, Calderdale and Huddersfield NHS Charity are in a good position to make firm plans for the future and the continuation and growth across all levels of activity.

The impact of Covid-19 restrictions on charities, in particular community and event fundraising is still being felt, alongside a downturn in the nation's economy. However Calderdale and Huddersfield NHS Charity are confident that by developing a robust plan and strategy for the longer term, with clear objectives and goals the Charity can continue to grow and develop its fundraising and communications, its ability to have a clear and demonstrable impact, meeting its objects as a charity and ensure it is governed well and compliant against its obligations.

Calderdale and Huddersfield NHS Charity has plans to embed its activities firmly within Calderdale and Huddersfield NHS Foundation Trust, and as part of the future plans for the NHS Trust, play an active part in identifying specific projects and initiatives to support.

Following consultation with the Charitable Funds Committee in May 2021, here are the highlights from the new 2 year charity strategy and plan.

Key Points from the Plan

- To achieve a growth in the voluntary income, year on year from new, regular fundraising activity.
- To grow the Charity brand representation and identity throughout CHFT and within the local community.
- To invest in the Charity team and provide the resources necessary to meet new challenges and opportunities ahead.
- Following on from the large scale fundraising and promotion NHS Charities have received in response to Covid-19, the plan aims to continue to strengthen the local profile of the Charity with the aspiration that it will become and in parts remain a preferred charity of choice within the local community.
- To install modern systems that enable effective donor relationship management with the ability to identify and quantify all income streams and their financial effectiveness
- To undertake proactive prospecting (across all areas of fundraising) to support the growth of the charities' income and impact.
- Increase longer term legacy income through developing wider exposure of the need for legacies in the future; to develop Tribute Funds and In Memory as key elements for the Charity and strengthen relationships with individual families.
- Review charity governance and operations, ensuring a robust risk management system is in operation, highlighting and managing risk across all activities.

11. REFERENCE AND ADMINISTRATIVE DETAILS

Calderdale and Huddersfield NHS Charity	
Registered Charity Number	1103694
Governing Document	The governing document, dated 18 March 2004, is a Trust Deed setting out how the Charity should be operated and incorporates the regulations to which it must abide.
Principal and Registered Office	Calderdale & Huddersfield NHS Foundation Trust Trust Headquarters, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA. T: 01484 344 344

11.1. CHARITABLE OBJECTS

The object of the Charity is to apply income received from donations and legacies to any charitable purpose or purposes relating to the NHS to benefit the public served by the Trust. The Corporate Trustee fulfils its legal duty by ensuring that funds are spent in accordance with the objects of each fund and, in designating funds, the Corporate Trustee respects the wishes of donors to benefit patient care and advance the good health and welfare of patients, carers and staff.

The Corporate Trustee confirms that it has referred to the guidance contained in the Charity Commission's general guidance on public benefit when reviewing the Trust's aims and objectives and in planning future activities.

The longer term aim of the Charity is to continue applying income received from donations and legacies to benefit the public served by the Trust, whilst maintaining minimal levels of reserves.

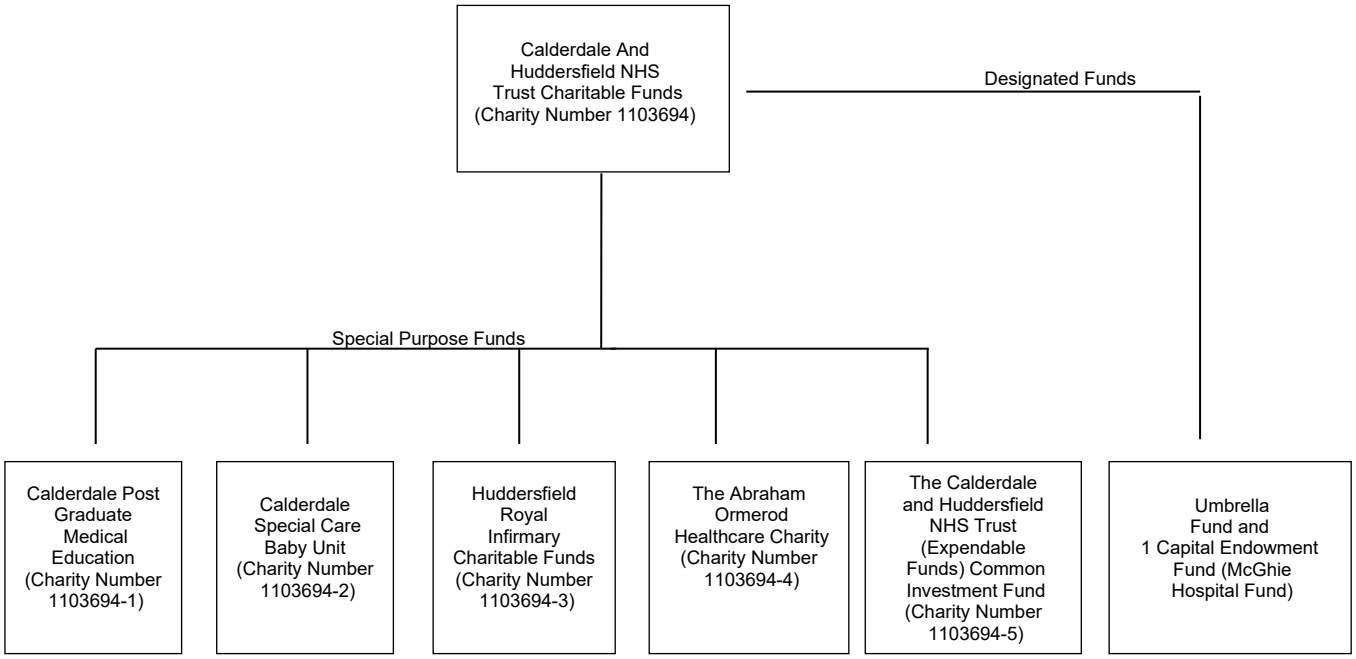
11.2. IMPACT AND MEETING OBJECTS

The Charity closely manages all aspects of charitable fund expenditure, reviewing and evaluating outcome and impact across all levels and purposes of funding.

Through on-going monitoring and gathering of data related to the expenditure of donations – the Charity is able to showcase its impact through the form of case studies and outcome reporting, all of which is publically available.

11.3. FUND STRUCTURE AND LINKED CHARITIES

Calderdale and Huddersfield NHS Charity comprises of the Umbrella Fund and five Special Purpose Funds. Each of the five special purpose funds (linked charities) share the same charity number as Calderdale and Huddersfield NHS Charity and have the same Trustee.



The designated funds receive income mainly through legacies and donations. On accepting such income no legal obligation is created as to its expenditure but it is the intention of the Corporate Trustee that any income received into Charitable Funds will be spent in line, as far as possible, with the wishes of the donor. It is to this end therefore that separate accounts are kept within the Umbrella fund for each of the designated funds.

The only income which the McGhie Hospital fund attracts is dividends on the capital investment. These funds are a permanent endowment; the income from the capital is to be split equally between the general purpose funds for Calderdale and Huddersfield.

Of the 5 special purpose funds registered with the Charity Commission, Calderdale Post Graduate Medical Education (PGME), Calderdale Special Care Baby Unit (SCBU) and Huddersfield Royal Infirmary also receive income from legacies and donations but have restrictions on where the funds can be spent.

The Calderdale and Huddersfield NHS Trust (Expendable Funds) Common Investment fund is a scheme that is registered with the Charity Commission that allows the Charity to combine the investment and money belonging to a number of funds into one pooled fund.

Each fund has at least one fund manager and funds are grouped by division.

The responsibility for approving expenditure of less than £500 from Charitable Funds has been delegated to the fund manager. For amounts that are greater than £500 further additional approval is required depending on the amount and type of expenditure. This could be a General Manager, Assistant Director of Nursing/Finance or higher level.

11.4. FUND MANAGEMENT

Calderdale and Huddersfield NHS Charity makes grants from both its unrestricted and restricted funds. The grants from restricted funds must be used in accordance with the conditions attached to the donation.

Unrestricted funds, grants are made from general purpose funds and designated (earmarked) funds.

- **General funds.** These funds are received with no particular preference expressed by donors. The Charitable Funds Committee invites applications from any member of staff to this fund. Based on their knowledge of the Trust, the Committee agree funding priorities and score applications for quality and value for money.
- **Designated funds.** Contain donations where a particular part of the hospital or activity was nominated for support by the donor at the time their donation was made. Whilst their nomination is not binding on the trustee, the designated funds reflect these nominations. The designated funds are overseen by fund managers who can make recommendations on how to spend the money within their designated area.

11.5. PROFESSIONAL ADVISORS

Principal Professional Advisors

Bankers	National Westminster Bank plc 8 Market Place Huddersfield HD1 2AL
Investment Managers	CCLA Investment Management Ltd Senator House 85 Queen Victoria Street London EC4V 4ET
Auditors	KPMG LLP (UK) 1 Sovereign Square Sovereign Street Leeds LS1 4DA
Legal Advisors	Hempsons Solicitors The Exchange Station Parade Harrogate HG1 1TS

12. STATEMENT OF TRUSTEES' RESPONSIBILITIES IN RESPECT OF THE TRUSTEES' ANNUAL REPORT AND THE FINANCIAL STATEMENTS

Under charity law, the trustees are responsible for preparing a Trustees' Annual Report and the financial statements in accordance with applicable law and regulations. The trustees are required to prepare the financial statements in accordance with UK Accounting Standards, including FRS 102 *The Financial Reporting Standard applicable in the UK and Republic of Ireland.*

The financial statements are required by law to give a true and fair view of the state of affairs of the charity and of the incoming resources and application of resources for that period.

In preparing these financial statements, generally accepted accounting practice entails that the trustees:

- select suitable accounting policies and then apply them consistently;
- make judgements and estimates that are reasonable and prudent;
- state whether applicable UK Accounting Standards and the Statement of Recommended Practice have been followed, subject to any material departures disclosed and explained in the financial statements;
- state whether the financial statements comply with the trust deed [and rules], subject to any material departures disclosed and explained in the financial statements;
- assess the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use the going concern basis of accounting unless they either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

The trustees are required to act in accordance with the trust deed [and the rules] of the charity, within the framework of trust law. They are responsible for keeping accounting records which are sufficient to show and explain the charity's transactions and disclose at any time, with reasonable accuracy, the financial position of the charity at that time, and to enable the trustees to ensure that, where any statements of accounts are prepared by them under section 132(1) of the Charities Act 2011, those statements of accounts comply with the requirements of regulations under that provision. They are responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error, and have general responsibility for taking such steps as are reasonably open to them to safeguard the assets of the charity and to prevent and detect fraud and other irregularities.

The trustees are responsible for the maintenance and integrity of the financial and other information included on the charity's website. Legislation in the UK governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

By Order of the Corporate Trustee

Signed Mr Philip Lewer, Chairman …… Philip Lewer ……

Signed

Mrs Kirsty Archer, Acting Director of Finance …… K. Archer ……Dated 30th September 2021

13. Independent auditor's report to the Trustees of Calderdale and Huddersfield NHS Foundation Trust Charitable Funds

Opinion

We have audited the financial statements of Calderdale and Huddersfield NHS Foundation Trust Charitable Funds ("the charity") for the year ended 31 March 2021 which comprise the Statement of Financial Activities, Balance Sheet and 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 charity's affairs as at 31 March 2021 and of its incoming resources and application of resources for the year then ended;
- have been properly prepared in accordance with UK accounting standards, including FRS 102 The Financial Reporting Standard applicable in the UK and Republic of Ireland; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We have been appointed as auditor under section 149 of the Charities Act 2011 (or its predecessors) and report in accordance with regulations made under section 154 of that Act.

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 charity 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 trustees have prepared the financial statements on the going concern basis as they do not intend to liquidate the charity or to cease its operations, and as they have concluded that the charity's financial position means that this is realistic. 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 trustees' conclusions, we considered the inherent risks to the charity's business model and analysed how those risks might affect the charity's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the trustees' 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 trustees' assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the charity'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 charity will continue in operation.

13. Independent auditor's report to the Trustees of Calderdale and Huddersfield NHS Foundation Trust Charitable Funds (continued)

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, Charitable Fund Committee and inspection of policy documentation as to the Charity's high-level policies and procedures to prevent and detect fraud, as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Trust Board, Audit and Risk Committee and Charitable Fund Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Charity'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 perform procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk that donations and legacies are recorded in the wrong period and the risk that management may be in a position to make inappropriate accounting entries and the risk of bias in accounting estimates and judgements such as asset valuations and impairments.

We did not identify any additional fraud risks.

In determining the audit procedures we took into account the results of our evaluation and testing of the operating effectiveness of some of the Trust-wide fraud risk management controls.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on high risk criteria and comparing the identified entries to supporting documentation. These included unusual journal characteristics linked to investments and cash.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Assessing the completeness, existence and accuracy of recorded income and expenditure through pre and post year end cut off testing.

Identifying and responding to risks of material misstatement due 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 Trustees and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

13. Independent auditor's report to the Trustees of Calderdale and Huddersfield NHS Foundation Trust Charitable Funds (continued)

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 Charity is subject to laws and regulations that directly affect the financial statements including 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 Charity 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

The trustees are responsible for the other information, which comprises the Trustees' Annual Report. 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. We are required to report to you if:

- based solely on that work, we have identified material misstatements in the other information; or
- in our opinion, the information given in the Trustees' Annual Report is inconsistent in any material respect with the financial statements.

We have nothing to report in these respects.

Matters on which we are required to report by exception

Under the Charities Act 2011 we are required to report to you if, in our opinion:

- the charity has not kept sufficient accounting records; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

We have nothing to report in these respects.

13. Independent auditor's report to the Trustees of Calderdale and Huddersfield NHS Foundation Trust Charitable Funds (continued)

Trustees' responsibilities

As explained more fully in their statement set out on page 38, the trustees are responsible for: the preparation of financial statements which give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the charity'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 either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

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.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the charity's trustees as a body, in accordance with section 149 of the Charities Act 2011 (or its predecessors) and regulations made under section 154 of that Act. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and its trustees, as a body, for our audit work, for this report, or for the opinions we have formed.

Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
KPMG LLP is eligible to act as an auditor in terms of section 1212 of the Companies Act 2006

1 Sovereign Square
Sovereign St
Leeds
LS1 4DA

01 October 2021

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

STATEMENT OF FINANCIAL ACTIVITIES FOR THE YEAR ENDED 31 MARCH 2021

	Notes	Unrestricted funds £'000	Restricted funds £'000	Endowment funds £'000	**2020/21 Total funds £'000**	2019/20 Total funds £'000
Income and endowments from:						
Donations and legacies	3	699	136	0	**835**	**386**
Charitable Activities	4	0	144	0	**144**	**35**
Investments	5	4	0	0	**4**	**4**
Other	5	0	0	0	**0**	**11**
Total incoming resources		**703**	**280**	**0**	**983**	**436**
Expenditure on:						
Raising funds	6	52	6	0	**58**	**52**
Charitable activities	7					
Purchase of new equipment		123	45	0	**168**	**215**
New building and refurbishment		30	9	0	**39**	**108**
Staff education and welfare		53	191	0	**244**	**110**
Patient education and welfare		128	42	0	**170**	**79**
Contribution to NHS		0	0	0	**0**	**0**
Total charitable activities		**334**	**287**	**0**	**621**	**512**
Other resources expended		**0**	**15**	**0**	**15**	**71**
Total expenditure	8	**386**	**308**	**0**	**694**	**635**
Net gains on investments	13	328	190	20	**538**	**18**
Net income/(expenditure)		**645**	**162**	**20**	**827**	**(181)**
Transfers between funds	10	(42)	42	0	**0**	**0**
Net movement in funds		**603**	**204**	**20**	**827**	**(181)**
Reconciliation of Funds						
Total Funds brought forward		1,443	832	98	**2,373**	**2,554**
Total funds carried forward		**2,046**	**1,036**	**118**	**3,200**	**2,373**

The notes 1-24 on the following pages form part of these financial statements. All income and expenditure are derived from continuing operations.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

BALANCE SHEET AS AT 31 MARCH 2021

	Notes	Unrestricted funds £'000	Restricted funds £'000	Endowment funds £'000	**Total at 31 March 2021 £'000**	Total at 31 March 2020 £'000
Fixed assets						
Investments	13	1,521	997	118	**2,636**	2,238
Total fixed assets		**1,521**	**997**	**118**	**2,636**	**2,238**
Current assets						
Debtors	14	6	1	0	**7**	49
Cash and cash equivalents	15	575	50	0	**625**	187
Total current assets		**581**	**51**	**0**	**632**	**236**
Liabilities						
Creditors: amounts falling due within one year	16	56	12	0	**68**	101
Net current assets / (liabilities)		**525**	**39**	**0**	**564**	**135**
Total assets less current liabilities		**2,046**	**1,036**	**118**	**3,200**	**2,373**
Total net assets		**2,046**	**1,036**	**118**	**3,200**	**2,373**
Funds of the charity	19					
Endowment funds		0	0	118	**118**	**98**
Restricted income funds		0	1,036	0	**1,036**	**832**
Unrestricted income funds		2,046	0	0	**2,046**	**1,443**
Total funds		**2,046**	**1,036**	**118**	**3,200**	**2,373**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

STATEMENT OF CASH FLOWS AS AT 31 MARCH 2021

	Note	Total at 31 March 2021 £'000	Total at 31 March 2020 £'000
Cash flows from operating activities:			
Net cash provided by (used in) operating activities	18	**294**	**(233)**
Cash flows from investing and other activities:			
Dividends from investments	5	4	4
Other income	5	0	11
Net cash provided by (used in) investing activities		**4**	**15**
Receipt from sale of investments	13	140	196
Net cash provided by financial investment		**140**	**196**
Change in cash and cash equivalents in the reporting period		438	(22)
Cash and cash equivalents at the beginning of the reporting period	15	187	209
Cash and cash equivalents at the end of reporting period	15	**625**	**187**

The notes on 1-24 on the following pages form part of these accounts. The financial statements and the accompanying notes were approved by the Board of Directors 30th September 2021 and were signed on its behalf by Kirsty Archer, Acting Director of Finance.

Signed ..... Philip Lewer ..... Mr Philip Lewer, Chairman

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

NOTES TO THE ACCOUNTS

1 Accounting policies

a) Basis of preparation

The financial statements have been prepared under the historic cost convention with the exception of investments which are included at fair value.

The financial statements have been prepared in accordance with the Statement of Recommended Practice: Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 and the Financial Reporting Standard applicable in the United Kingdom and Republic of Ireland (FRS 102) and the Charities Act 2011 and UK Generally Accepted Practice as it applies from 1 January 2019.

The financial statements have been prepared to give a 'true and fair' view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a 'true and fair view'. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in October 2019 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has since been withdrawn.

The Corporate Trustee considers that there are no material uncertainties about the Charity's ability to continue as a going concern. The Covid-19 pandemic has had an impact on the Charity's fundraising income for unrestricted funds although this is partially offset by the generous donations made by members of the public in the first lockdown and restricted income from the NHS Charities Together national appeal.

b) Governance costs

Governance costs are classified as support costs and have therefore been apportioned across charitable activities, after a portion has been allocated to Raising Funds. These costs include costs related to the statutory audit and an apportionment of overhead and other support costs.

The analysis of support costs, including governance costs, is shown in note 9.

c) Structure of funds

Unrestricted income funds comprise those funds which the Corporate Trustee is free to use for any purpose in furtherance of its charitable objectives. Unrestricted funds include designated funds where the donor has made known their non-binding wishes or where the Corporate Trustee, at its discretion, has created a fund for a specific purpose.

Restricted funds are those which are to be used in accordance with specific restrictions imposed by the donor. The Charity has six restricted funds. The restrictions on CRH SCBU, CRH PGME and HRI Special Purpose funds (see note 19) primarily limit any expenditure from these funds to be undertaken for the benefit of the stated purpose contained in the fund title. The fourth and fifth restricted funds are the Abraham Ormerod Centre fund and the Abraham Ormerod Reserve fund. They both have the same restriction which is that the approved expenditure must, where possible, be for services provided for the benefit of people in the Todmorden area. The sixth restricted fund is the Covid-19 fund where the grants from NHS Charities Together were allocated.

Endowment Funds are where capital is held to generate income for charitable purposes with no discretion to spend capital. The Charity has one permanent endowment fund, McGhie Hospital.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

Accounting Policies (continued)

d) Incoming resources
All incoming resources are recognised once the Charity has entitlement to the resources, it is probable (more likely than not) that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

Donations are recognised when the Charity has been notified in writing of both the amount and settlement date.

Interest on funds held on deposit is included when receivable and the amount can be measured reliably by the Charity; this is normally upon notification of the interest paid or payable by the bank. Dividends are recognised once the dividend has been declared and notification has been received of the dividend due. This is normally upon notification by our investment advisor of the dividend yield of the investment portfolio.

e) Gifts in kind
Gifts in kind, such as food and care packages are not accounted for when they are accepted and immediately distributed unless a single donation is material.
Gifts of tangible assets such as mattresses and fridges are recognised as a donation at fair value (market price) on receipt and charitable expenditure when they are distributed.
Where gifts in kind are held before being distributed to beneficiaries, they are recognised at fair value as stock until they are distributed.

f) Incoming resources from legacies
Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable; this will be once confirmation has been received from representatives of the estate(s) that probate has been granted, the executors have established that there are sufficient assets in the estate to pay the legacy and all conditions attached to the legacy have been fulfilled or are within the Charity's control.

If there is uncertainty as to the amount of the legacy and it cannot be reliably estimated, then the legacy is shown as a contingent asset until all of the conditions for income recognition are met (see Note 20 - Material legacies).

g) Resources expended
All expenditure is accounted for on an accruals basis and has been classified under headings that aggregate costs related to each category of expense shown in the Statement of Financial Activities. All expenditure is recognised once there is a legal constructive obligation committing the Charity to the expenditure.

h) Irrecoverable VAT
Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

i) Allocation of support costs
Support costs are those costs which do not relate directly to a single activity. These include some staff costs, costs of administration and audit costs. They are allocated to charitable activities, across the funds in proportion to total expenditure, as shown in note 9, after a portion has been allocated to Raising Funds.

j) Fundraising costs
The costs of generating funds are those costs attributable to generating income for the Charity, other than those costs incurred in undertaking charitable activities. These are fundraising costs and they

include expenses for fundraising activities and a fee paid to Calderdale & Huddersfield NHS Foundation Trust to pay the salary and overhead costs of the fundraising team – see note 6.

k) Charitable activities
Costs of Charitable Activities comprise all costs incurred in the pursuit of charitable objects of the Charity. These costs comprise direct costs and overhead and support costs.

l) Fixed asset investments
Investments are initially recognised at their transaction value and are subsequently measured at the current market value quoted by the investment analyst, as at the balance sheet date. The Statement of Financial Activities includes the net gains and losses arising on revaluation.

The main form of financial risk faced by the Charity is that of volatility in equity markets and investment markets due to wider economic conditions and the attitude of investors to investment risk.

m) Debtors
Debtors are amounts owed to the Charity. They are measured on the basis of their recoverable amount.

n) Cash and cash equivalents
Cash at bank and in hand is held to meet the day to day running costs of the Charity as they fall due. Cash equivalents are balances held in the deposit account which are very liquid funds and are now shown as part of ‘Cash and cash equivalents’ on the balance sheet. There is no impact on the total funds of the Charity. An analysis of Cash and cash equivalents is provided in note 15.

o) Creditors
Creditors are amounts owed by the Charity. They are measured at the amount that the Charity expects to have to pay to settle the debt.

p) Recognised gains and losses
All gains and losses are taken to the Statement of Financial Activities as they arise. Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or value at date of purchase if later).

2 Prior year comparatives by type of fund

The primary statements provide prior year comparatives in total; this note provides prior period comparatives for the Statement of Financial Activities and the Balance Sheet for each of the three types of fund that the Charity manage.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

NOTES TO THE ACCOUNTS

2a Unrestricted funds

Statement of financial activity for the year ended 31 March 2021

	2021 £'000	2020 £'000
Income and endowments from:		
Donations and legacies	699	374
Charitable Activities	0	35
Investments	4	4
Other	0	11
Total income and endowments	**703**	**424**
Expenditure on:		
Raising funds	52	3
Charitable activities		
Purchase of new equipment	123	191
New building and refurbishment	30	107
Staff education and welfare	53	105
Patient education and welfare	128	56
Contribution to NHS	0	0
Total charitable activities	**334**	**459**
Total expenditure	**386**	**462**
Net gains on investments	328	14
Net income/(expenditure)	**645**	**(24)**
Transfers between funds	**(42)**	**0**
Net movement in funds	**603**	**(24)**
Reconciliation of Funds		
Total Funds brought forward	1,443	1,467
Total funds carried forward	**2,046**	**1,443**

Balance sheet as at 31 March 2021

	2021 £'000	2020 £'000
Fixed assets		
Investments	1,521	1,313
Total fixed assets	**1,521**	**1,313**
Current assets		
Debtors	6	49
Cash and cash equivalents	575	180
Total current assets	**581**	**229**
Liabilities		
Creditors: amounts falling due within one year	56	99
Net current assets / (liabilities)	**525**	**130**
Total assets less current liabilities	**2,046**	**1,443**
Total net assets	**2,046**	**1,443**
Total unrestricted funds	**2,046**	**1,443**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

NOTES TO THE ACCOUNTS

2b Restricted funds

Statement of financial activity for the year ended 31 March 2021

	2021 £'000	2020 £'000
Income and endowments from:		
Donations and legacies	136	12
Charitable Activities	144	0
Total income and endowments	**280**	**12**
Expenditure on:		
Raising funds	6	49
Charitable activities		
Purchase of new equipment	45	24
New building and refurbishment	9	1
Staff education and welfare	191	5
Patient education and welfare	42	23
Total charitable activities	**287**	**53**
Other resources expended	**15**	**71**
Total expenditure	**308**	**173**
Net gains on investments	190	7
Net income/(expenditure)	**162**	**(154)**
Transfers between funds	**42**	**0**
Net movement in funds	**204**	**(154)**
Reconciliation of Funds		
Total Funds brought forward	832	986
Total funds carried forward	**1,036**	**832**

Balance sheet as at 31 March 2021

	2021 £'000	2020 £'000
Fixed assets		
Investments	997	827
Total fixed assets	**997**	**827**
Current assets		
Debtors	1	0
Cash and cash equivalents	50	7
Total current assets	**51**	**7**
Liabilities		
Creditors: amounts falling due within one year	12	2
Net current assets / (liabilities)	**39**	**5**
Total assets less current liabilities	**1,036**	**832**
Total net assets	**1,036**	**832**
Total restricted funds	**1,036**	**832**

2c Endowment funds

Statement of financial activity for the year ended 31 March 2021

	2021 £'000	2020 £'000
Net gains or (losses) on investments	20	(3)
Net income/(expenditure)	**20**	**(3)**
Transfers between funds	**0**	0
Net movement in funds	**20**	**(3)**
Reconciliation of Funds		
Total Funds brought forward	98	101
Total funds carried forward	**118**	**98**

Balance sheet as at 31 March 2021

	2021 £'000	2020 £'000
Fixed assets		
Investments	118	98
Total fixed assets	**118**	**98**
Total assets less current liabilities	**118**	**98**
Total net assets	**118**	**98**
Total endowment funds	**118**	**98**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

NOTES TO THE ACCOUNTS

3 Analysis of voluntary income

	Unrestricted funds	Restricted funds	Endowment funds	**2020/21 Total funds**	2019/20 Total funds
	£'000	£'000	£'000	**£'000**	£'000
Donations	116	80	0	**196**	137
Corporate donations	547	56	0	**603**	177
Legacies	36	0	0	**36**	72
	699	**136**	**0**	**835**	**386**

Donations of gifts in kind to the value of £42,800 are included in income, valued at their market value. All of these donations have been distributed during the year. The 2019/20 figures have been restated to take into account that £35,000 is now shown below in Note 4; Charitable Activities (NHS Charities Together grants) are shown on a separate line in the SOFA.

4 Analysis of income from charitable activities (NHS Charities Together grants)

	Unrestricted funds	Restricted funds	Endowment funds	**2020/21 Total funds**	2019/20 Total funds
	£'000	£'000	£'000	**£'000**	£'000
Stage 1 grant (1st part)	0	0	0	**0**	35
Stage 1 grant (2nd part)	0	42	0	**42**	0
Stage 2 grant (1st part)	0	50	0	**50**	0
Stage 2 grant (2nd part)	0	50	0	**50**	0
Grant in association with Starbucks	0	2	0	**2**	0
	0	**144**	0	**144**	**35**

In 2020/21, the Charity received grants from the NHS Charities Together Covid-19 emergency appeal.

5 Total income from operating activities

Income from investments

	Unrestricted funds	Restricted funds	Endowment funds	**2020/21 Total**	2019/20 Total
	£'000	£'000	£'000	**£'000**	£'000
Fixed asset investments UK	4	0	0	**4**	4
	4	**0**	**0**	**4**	**4**

The dividends above relate to the McGhie Hospital fund; these are shared equally between both General Purpose funds.

Other Income

Other income is £nil (£11,000 in 2019/20). Last year this was wholly attributable to Breast Milk Bank Income which is in an unrestricted fund.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

NOTES TO THE ACCOUNTS

6 Analysis of expenditure on raising funds

In 2020/21 the Charity continued to use only one investment manager. For the current year, the fee for the COIF Charities Investment fund is 0.60% which is charged annually based on the capital balance (2019/20: 0.60%).

	Unrestricted funds	Restricted funds	Endowment funds	**2020/21 Total funds**	2019/20 Total funds
	£'000	£'000	£'000	**£'000**	£'000
Fundraising Costs	50	4	0	**54**	49
Support Costs	2	2	0	**4**	3
	52	**6**	**0**	**58**	**52**

The fundraising costs above include staff costs, memberships, marketing and resources and other fundraising event costs.

7 Analysis of charitable expenditure

The Charity made grant support available to Calderdale and Huddersfield NHS Foundation Trust and Locala Community Partnership for the purchase of equipment and contributions for staff and patient education, amenities and welfare.

	Grant funded activity			Support costs			Total 2020/21			
	Unrestricted funds	Restricted funds	Total funds	Unrestricted funds	Restricted funds	Total funds	Unrestricted funds	Restricted funds	**Total 2020/21**	Total 2019/20
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	**£'000**	£'000
Purchase of new equipment	116	43	159	7	2	9	123	45	**168**	215
New building and refurbishment	29	8	37	1	1	2	30	9	**39**	108
Staff education,welfare and amenities	50	180	230	3	11	14	53	191	**244**	110
Patient education,welfare and amenities	121	40	161	7	2	9	128	42	**170**	79
	316	**271**	**587**	**18**	**16**	**34**	**334**	**287**	**621**	**512**

The Charity also made available grant support of £15,000 (2019/20: £71,000) – see details in the Financial Review; this was to Age Concern Todmorden towards its running costs.

8 Analysis of grants

The main beneficiary of the Charity is the related party, Calderdale and Huddersfield NHS Foundation Trust, but grants are also made to Locala Community Partnership. The Corporate Trustee operates a scheme of delegation through which all grant funded activity is managed by fund managers responsible for the day to day disbursements from their designated funds in accordance with the directions set out in the Charity standing orders and standing financial instructions.

	2020/21	2019/20
	£'000	£'000
Raising funds	**58**	52
Grants made:		
NHS Foundation Trust	621	502
Locala Community Partnership	0	10
	621	512
Other Resources Expended	**15**	71
Total resources expended	**694**	**635**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

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9 Allocation of governance and support costs

Support and overhead costs are apportioned to charitable activities according to the value of transactions that have occurred within each activity in the year. Governance costs are those support costs which relate to the strategic and day to day management of the Charity.

Support and governance costs	Raising Funds	Charitable Activities	**2020/21 Total £'000**	2019/20 Total £'000
Financial services	3	24	**27**	**27**
Salaries and related costs	0	4	**4**	**4**
External and internal audit costs	1	5	**6**	**4**
Establishment costs	0	1	**1**	**1**
	4	**34**	**38**	**36**

Support and governance costs	Unrestricted funds £'000	Restricted funds £'000	Endowment funds £'000	**2020/21 Total £'000**	2019/20 Total £'000
Raising funds	2	2	0	**4**	**3**
Charitable Activities	18	16	0	**34**	**33**
	20	**18**	**0**	**38**	**36**

Support and governance costs for charitable activities	Unrestricted funds £'000	Restricted funds £'000	Endowment funds £'000	**2020/21 Total £'000**	2019/20 Total £'000	2021 Basis of apportionment to charitable activities
Financial services	14	11	0	**25**	**25**	Proportionate to charitable expenditure
Salaries and related costs	2	2	0	**4**	**4**	Proportionate to charitable expenditure
External and internal audit costs	2	2	0	**4**	**3**	Proportionate to charitable expenditure
Establishment costs	0	1	0	**1**	**1**	Proportionate to charitable expenditure
	18	**16**	**0**	**34**	**33**	

Apportionment of support costs across charitable expenditure	Purchase of Equipment £'000	Staff Education and Welfare £'000	Patient Education and Welfare £'000	Building & Refurbishment £'000	Other £'000	**2020/21 Total £'000**	2019/20 Total £'000
Financial services	7	9	7	2	0	**25**	**25**
Salaries and related costs	1	2	1	0	0	**4**	**4**
External and internal audit costs	1	2	1	0	0	**4**	**3**
Establishment costs	0	1	0	0	0	**1**	**1**
	9	**14**	**9**	**2**	**0**	**34**	**33**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

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10 Transfers between funds

There was a transfer in April 20 of £42,000 from an unrestricted General Purpose fund to the newly set up restricted Covid-19 fund (2019/20: £nil).

11 Analysis of staff costs

The Charity does not directly employ any members of staff. The administration and fundraising are carried out by staff from the Trust and recharged to the Charity. For 2020/21 the recharged staff cost for administration was £31,334 (2019/20: £31,112). The recharged staff cost for fundraising was £48,637 (2019/20: £42,276).

12 Auditor's remuneration

The auditor's remuneration of £3,840 - inclusive of VAT (2019/20: £3,840 – inclusive of VAT) related solely to the statutory audit, with no other additional work undertaken (2019/20: £nil).

13 Fixed asset investments

All investments are made in accordance with the guidance issued by the Charity Commission. The current investments are managed by CCLA.
Funds are either invested in the stock exchange, other securities or held to gain interest in the bank. The Charity's investment objective remains the same, that is, to provide a balance between long term capital growth, security, availability and maximisation of annual income. All investments are carried at their fair value.

Movement in year

	2020/21 £'000	2019/20 £'000
Market value at 1 April	2,238	2,416
Add : additions at cost	0	0
Less : disposals at market value and in year gain/(loss) on disposal	(140)	(196)
Add/Less : gain/loss on revaluation	538	18
Add : gain/(loss) on in year disposals	0	0
Less : movements in broker held bank accounts	0	0
Market value at 31 March	**2,636**	**2,238**

The impact of the pandemic on the value of our investments can be seen at the end of March 2020 when the stock market was low, resulting in an unrealised gain on investments in 2019/20 of only £18,000. However, during 2020/21, the stock market recovered and an unrealised gain of £538,000 was reported at the end of March 2021. Gains or losses on revaluation are realised at such times when investments are sold.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

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Fixed asset investments (cont.)

Investments in common investment funds

	Units held at 31 March 2021	31 March 2021 total £'000	Units held at 31 March 2020	31 March 2020 total £'000
CCLA Investments Management Ltd				
COIF Charities Investment Fund				
Accumulation units	12,153	2,518	12,843	2,140
Income units	6,602	118	6,602	98
	18,755	**2,636**	**19,445**	**2,238**

Risk Strategy in terms of investments held with investment managers

In line with the investment objectives of the Charity, it is essential that the correct balance of risk and rewards is conveyed to the Investment Managers running the Charity portfolios.

The view of the Charitable Funds Committee is that risk levels should be based on Low and Medium risk.

Low risk
The Charity is prepared to accept a small degree of short term volatility, in the hope of producing slightly higher returns. The Charity seeks to reduce the risk of returns being exceeded by inflation, while retaining a consistent pattern of returns and accepts the possibility of frequent but minor fluctuations in capital value.

Medium risk
The Charity is prepared to accept risk of some short term volatility in the pursuit of returns over the medium to long term which should maintain capital after the effects of inflation and is aware that more significant fluctuations in capital are possible.

Liquidity risk
This is anticipated to be low as the Fund holds a diversified portfolio but one biased towards real assets including global equities, property and infrastructure, and with only modest exposure to bonds and cash.

Currency risk
There is an element of currency risk as there are some overseas equities within the portfolio but these should be minimal as the portfolio is diversified.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

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14 Analysis of debtors

Debtors under 1 year	31 March 2021 £'000	31 March 2020 £'000
Other debtors	7	49
Total	**7**	**49**

Other debtors represent any sums owed to the Charity by a related party, Calderdale and Huddersfield NHS Foundation Trust, for income collected by the Trust on behalf of the Charity (£5,000) and donations received but not banked until April 2021 (£2,000).

15 Analysis of cash and cash equivalents

Analysis of cash at bank	31 March 2021 £'000	31 March 2020 £'000
National Westminster current account	(1)	0
Short term investments and deposits		
National Westminster deposit account	626	187
Total	**625**	**187**

Note: Whilst National Westminster current account is showing a debit balance, it should be noted that this account did not go overdrawn and that the debit balance is due to cheques raised but not yet cashed.

16 Analysis of liabilities

Creditors under 1 year	31 March 2021 £'000	31 March 2020 £'000
Other creditors	68	101
	68	**101**

Other creditors mainly represent sums owed by the Charity to a related party, Calderdale and Huddersfield NHS Foundation Trust (£63,000), for costs incurred by the NHS Foundation Trust on behalf of the Charity in the furtherance of the Charity's objectives. It also includes the cost of items received but not yet invoiced (£5,000).

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

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17 Provisions for liabilities and charges

The Charity does not have any provisions for liabilities and charges and, as such, has not disclosed any such liabilities and charges in the Statement of Financial Activities.

18 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	31 March 2021 £'000	31 March 2020 £'000
Net income/(expenditure) for 2020/21 (as per SOFA)	**827**	**(181)**
Adjustments for:		
(Gains)/losses on investments	(538)	(18)
Dividends from investments	(4)	(4)
Other income	0	(11)
(Increase)/decrease in debtors	42	(45)
Increase/(decrease) in creditors	(33)	26
Net cash provided by (used in) operating activities	**294**	**(233)**

19 Analysis of charitable funds

	Balance at 31 March 2020 b/fwd	Incoming resources	Resources expended	Transfers	Gains and losses	Balance at 31 March 2021 c/fwd
	£'000	£'000	£'000	£'000	£'000	£'000
Endowment						
McGhie hospital	98	-	-	-	20	118
	98	**-**	**-**	**-**	**20**	**118**
Restricted						
CRH SCBU	13	4	(4)	-	-	13
CRH PGME	17	-	(1)	-	-	16
HRI special purpose fund	21	-	(4)	-	-	17
Covid 19 fund	-	276	(184)	42	-	134
Abraham Ormerod day hospital	493	-	(115)	-	-	378
Abraham Ormerod reserve	288	-	-	-	190	478
	832	**280**	**(308)**	**42**	**190**	**1,036**
Unrestricted						
Unrestricted funds	**1,443**	**703**	**(386)**	**(42)**	**328**	**2,046**
Total	**2,373**	**983**	**(694)**	**-**	**538**	**3,200**

All the unrestricted funds are designated funds and are available for any charitable purpose relating to the NHS but are mainly for the stated purpose contained in the fund title. This is in recognition of the non-binding wishes of donors when making their generous gifts.

In the interests of accountability and transparency a complete breakdown of all designated (earmarked) funds is available upon written request.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

NOTES TO THE ACCOUNTS

20 Material legacies

Legacy income is accounted for as incoming resources in the Statement of Financial Activities either upon receipt or where the legacy is probable. Material legacies are those which have been notified as at 31 March 2021 but not recognised as incoming resources in the Statement of Financial Activities due to the conditions for recognition not being met.

Material legacies as at 31 March 2021		2020/21	2019/20
Notification received from	Date notification received	Estimated value of legacy £'000	Estimated value of legacy £'000
Wilkinson Woodward Bearders Sols	March 2020	0	1
		0	**1**

21 Outstanding Approvals

Expenditure that has been approved internally but not yet delivered or services not yet provided has been summarised below.

Outstanding Expenditure Approvals as at 31 March 2021	2020/21	2019/20
Fund Manager	Estimated value £	Estimated value £
Calderdale & Huddersfield NHS Foundation Trust	511,401	617,874
	511,401	**617,874**

22 Related party transactions

Calderdale and Huddersfield NHS Foundation Trust is considered to be the main related party to the Charity. Payments to creditors are made through the Trust and reimbursed from the Charitable Funds. Whilst the Trust paid £610,105 on behalf of the Charity, all but £86 of this was repaid by the Charity; this latter figure represents the administration costs provided by the Trust. This cost, in support of the Charity's grant making activities, is included within support costs – see note 9.
During the year, a donation of £500,000 was received from Calderdale and Huddersfield Solutions Limited, a wholly owned subsidiary of Calderdale and Huddersfield NHS Foundation Trust.

23 Trustees' remuneration, benefits and expenses

During the year, no Board Member of the Trust received either remuneration or expenses and none of them, or key management staff, has undertaken any material transactions with the Calderdale and Huddersfield NHS Foundation Trust Charitable Funds. There were also no Trustee indemnity insurance costs during the year.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST CHARITABLE FUNDS

ACCOUNTS – 2020/21

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24 Role of volunteers

Our fund managers are, in effect, volunteers. There are about 200 Trust staff members who manage how the Charity's designated funds should be spent. Each fund manager has been delegated responsibility for approving expenditure of less than £500.

In addition the Charity has been supported this year by Charity volunteers, who have dedicated their time, skills and commitment to supporting the charity and its operations. We would like to say a big thank you to our volunteers for helping to support us at a time when we needed it most, and for all you have done to help 2020/21 be such a successful year.

Calderdale and Huddersfield NHS Charity

NHS
Calderdale and Huddersfield
NHS Foundation Trust

THANK YOU

"Your support will help us to keep improving facilities for staff and patients."

Give back to your Trust today.
Donate at: chftcharity.co.uk

Registered with FUNDRAISING REGULATOR
Charity Number: 1103694

compassionate care

Calderdale and Huddersfield NHS Charity

Calderdale and Huddersfield NHS Foundation Trust

Thanks to everyone for your continued support

Your donations can truly transform and change lives.

If you would like to find out more about donating to us email chftfundraising@cht.nhs.uk

2. Emergency Preparedness Resilience and Response (EPRR) Core Standards Submission

Yorkshire and the Humber Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2021-2022

STATEMENT OF COMPLIANCE

Calderdale & Huddersfield NHF Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0

Where areas require further action, Calderdale & Huddersfield NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Bev Walker

Acting Chief Operating Officer / Organisation's Accountable Emergency Officer

Friday 29th October 2021

13/01/2022	13/01/2022	01/10/2021
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Please select type of organisation: **Acute Providers**

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	5	5	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	9	5	4	0
Command and control	1	1	0	0
Response	5	5	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	7	5	2	0
CBRN	12	9	3	0
Total	48	39	9	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Oxygen Supply	7	7	0	0
Ambulance Resilience	0	0	0	0
Total	7	7	0	0

Key

Numbers to the standards have been changed by NHS England. 21 Standards have been remmoved from this years self assessment.

Overall assessment:	81.25% - Partial

Instructions:
Step 1: Select the type of organisation from the drop-down at the top of this page
Step 2: Complete the Self-Assessment RAG in the 'EPRR Core Standards' tab
Step 3: Complete the Self-Assessment RAG in the 'Deep dive' tab
Step 4: Ambulance providers only: Complete the Self-Assessment in the 'Interoperable capabilities' tab
Step 5: Click the 'Produce Action Plan' button below

Ref	Domain	Standard	Detail	Acute Providers	Evidence - examples listed below	Organisational Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance											
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director, and have the appropriate authority, resources and budget to direct the EPRR portfolio. A non-executive board member, or suitable alternative, should be identified to support them in this role.	Y	• Name and role of appointed individual	Bev Walker, AEO/COO	Fully compliant		Bev Walker		
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy statement. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes. The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested • Include references to other sources of information and supporting documentation.	Y	Evidence of an up to date EPRR policy statement that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	EPRR strategy originally ratified in Oct 2017. BCM Policy originally ratified in Nov 2017. BCM Internal Plans for services completed, tested and reviewed. Internal web page evidence based of template plans and exercise activities. Developed database stores risk assessments evidence and process. Specialised Incident Resonse Plans ratified and attached to the internal web page. Internal Security, Resilience Governance Group (SRGG) established with Calderdale & Huddersfield Foundation Trust (CHFT) Terms Of Reference, agendas and minutes of multiple groups. SRGG escalates and provides information to the Health & Safety Committee. Annual Work plan managed.	Fully compliant		Ian Kilroy		
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Y	• Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board	Report submitted to the H&S Committee and SRGG. Multiple Post Exercise Reports submitted to individual Service Boards. SRGG established. TOR agreed. Format of meeting agreed. Action programme agreed. Forwards to H&S Committee and WEB information shared. Annually NHS England EPRR Core Standards escalated to the Exec Board and a Resilience and Security Management Report.	Fully compliant		Ian Kilroy		
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource, proportionate to its size, to ensure it can fully discharge its EPRR duties.	Y	• EPRR Policy identifies resources required to fulfill EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff • Organisation structure chart • Internal Governance process chart including EPRR group	Resources funds discussed relating to ICC, SLiC, HAZMAT suits/tents. Review completed regards resources. Resilience and Security Manager JD in place. Resilience & Security Support Officer implemented. Administrative Suppoty agreed internally. Roles moved into Central Ops/Community Divisions group to be developed. Developing liaison with Patient Flow/THIS/CHS/ISS/Engie/ED	Fully compliant		Ian Kilroy		
6	Governance	Continuous improvement process	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the development of future EPRR arrangements.	Y	• Process explicitly described within the EPRR policy statement	Assessment of risk is completed. Examples - EU Exit, COVID, TDY, UCI, Tactical Command Group instigation - Pan Flu, EPR power outage, Medical Devices, Severe weather	Fully compliant		Ian Kilroy		
Domain 2 - Duty to risk assess											
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register	EPRR Database established. Equally UCI approach evidences decision and submission of rota and assurance process	Fully compliant		Ian Kilroy		
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring and escalating EPRR risks.	Y	• EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Implemented. Liaison with Risk Managemnt and risk register is regular - DATIX	Fully compliant		Ian Kilroy		
Domain 3 - Duty to maintain plans											

11	Duty to maintain plans	Critical incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a critical incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Developed and awaiting approval	Partially compliant	Draft Plan gathered and shared with the SRGG	Ian Kilroy/Karen Bates		
12	Duty to maintain plans	Major incident	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a major incident (as defined within the EPRR Framework).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	MIP originally implemented and reviewed in Sep 2017. Utilised plan in additional multi agency exercises of HAZMAT and Pan Flu. Current review process in place.	Partially compliant	Plan reviewed process in place and to be discussed, agreed and implemented at SRGG	Ian Kilroy		
13	Duty to maintain plans	Heatwave	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of heatwave on the population the organisation serves and its staff.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Plan reviewed and in place. Activated, exercised and tested in Jun 2019. Implemneted live on 25 Jul 2019. Review process in place.	Fully compliant		Ian Kilroy		
14	Duty to maintain plans	Cold weather	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to the impacts of snow and cold weather (not internal business continuity) on the population the organisation serves.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Winter Plan implemnted annually with due process of meetings, actions, priorities, assessment of risks. National Guidance situated on EPRR web page for further information. Review process in place.	Fully compliant		Ian Kilroy		
18	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to mass casualties. For an acute receiving hospital this should incorporate arrangements to free up 10% of their bed base in 6 hours and 20% in 12 hours, along with the requirement to double Level 3 ITU capacity for 96 hours (for those with level 3 ITU bed).	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Yorkshire and Humberside Regional Plan implented. Test Exercise was scheduled as Emergo in Nov 2019 and was implemented. KB and IK also attended the Emergo Trainer Course to utilise for future events. Review process in place.	Fully compliant		Ian Kilroy		
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Yorkshire and Humberside Regional Plan implented. Test Exercise was scheduled as Emergo in Nov 2019 and implemnted. KB and IK also attended the Emergo Trainer Course to utilise for future events. Review process in place.	Fully compliant		Ian Kilroy		
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Evacuation Plan originally completed and reviewed in 2018. Review process in place.	Partially compliant		Ian Kilroy		
21	Duty to maintain plans	Lockdown	In line with current guidance and legislation, the organisation has effective arrangements in place to safely manage site access and egress for patients, staff and visitors to and from the organisation's facilities. This should include the restriction of access / egress in an emergency which may focus on the progressive protection of critical areas.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Lock Down Plan instigated. Live incident occurred Jul 2019. Debrief occurred. Lessons learnt identified and distributed.Test Exercise in September 2019 planned and implemented. Lockdown currently under development of the Project ED at HRI too. Review process in place.	Fully compliant		Ian Kilroy		
22	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Y	Arrangements should be: • current (although may not have been updated in the last 12 months) • in line with current national guidance • in line with risk assessment • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referenced in Major Incident Plan	Partially compliant	Reviewed as part of the MIP	Ian Kilroy		
Domain 4 - Command and control											

24	Command and control	On-call mechanism	A resilient and dedicated EPRR on-call mechanism is in place 24 / 7 to receive notifications relating to business continuity incidents, critical incidents and major incidents. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Include 24 hour arrangements for alerting managers and other key staff.	On Call Management implemented. Rotas utilised. Switchboard Exercise completed. Developing Communication process through THIS.SLIC completed for 40+ staff. 2 further SLiC courses implemented Oct-Dec 2019. On Call Strategic/Tactical Group guidance issued booklet, JESIP, Corporate Induction. E-Learning On Call Management, Business Continuity and Incident Response Plans available and on internal web page. Addiionally, 2 training sessions delivered to On Call Management identified 50+ staff, through Nov 2018 focussed upon initial response, roles, legal context and implementation of Strategic/Tactical Manaement to respond to the crisis situation. CHS received additional 'Loss of Power' Exercise involving THIS, ISS, CHS services to 18+ staff. Post Report completed. Additionally obtained notebooks for On Call Manaagement Group. On Call Managemnt Group have monthly updates on clinically/non clinical areas and delivered through EPRR Lead and Team	Fully compliant		Ian Kilroy		
Domain 5 - Training and exercising										
Domain 6 - Response										
30	Response	Incident Co-ordination Centre (ICC)	The organisation has Incident Co-ordination Centre (ICC) arrangements	Y		Information gathered. Equipment purchased (Lanyards, Desks, Mobile Phones, Clocks, Radio, Laptops). Strategic and Tactical rooms established. ICC desks identified.	Fully compliant		Ian Kilroy/Karen Bates	
32	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans	BCM overarching database is co-ordinated by RSM. Incidents are reviewed via the DATIX system. Service plans and separate execise post resports are accessible, via internal web page. Completed.	Fully compliant		Karen Bates	
34	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to business continuity incidents, critical incidents and major incidents.	Y	• Documented processes for completing, signing off and submitting SitReps	COVID, EPR, Heatwave, EU Exit examples of evidence	Fully compliant		Ian Kilroy	
35	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Accessible resource and information is via the EPRR internal web page and link to NHS England web pages	Fully compliant		Ian Kilroy	
36	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the PHE 'CBRN incident: Clinical Management and health protection' guidance.	Y	• Guidance is available to appropriate staff either electronically or hard copies	Accessible via the EPRR internal web page	Fully compliant		Ian Kilroy	
Domain 7 - Warning and informing										
37	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements to communicate with partners and stakeholder organisations during and after a major incident, critical incident or business continuity incident.	Y	• Have emergency communications response arrangements in place • Social Media Policy specifying advice to staff on appropriate use of personal social media accounts whilst the organisation is in incident response • Using lessons identified from previous major incidents to inform the development of future incident response communications • Having a systematic process for tracking information flows and logging information requests and being able to deal with multiple requests for information as part of normal business processes • Being able to demonstrate that publication of plans and assessments is part of a joined-up communications strategy and part of your organisation's warning and informing work	Communicaions Strategy in place. Communications Team co-ordinate any incidents through due process. Example of Emergo, EU Exit, HAZMAT and Lockdown.	Fully compliant		Comms Team	
38	Warning and informing	Warning and informing	The organisation has processes for warning and informing the public (patients, visitors and wider population) and staff during major incidents, critical incidents or business continuity incidents.	Y	• Have emergency communications response arrangements in place • Be able to demonstrate consideration of target audience when publishing materials (including staff, public and other agencies) • Communicating with the public to encourage and empower the community to help themselves in an emergency in a way which compliments the response of responders • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing	Communicaions Strategy in place. Commubnications Team co-ordinate any incidents through due process. Example of Emergo, EU Exit, HAZMAT and Lockdown.	Fully compliant		Comms Team	
39	Warning and informing	Media strategy	The organisation has a media strategy to enable rapid and structured communication with the public (patients, visitors and wider population) and staff. This includes identification of and access to a media spokespeople able to represent the organisation to the media at all times.	Y	• Have emergency communications response arrangements in place • Using lessons identified from previous major incidents to inform the development of future incident response communications • Setting up protocols with the media for warning and informing • Having an agreed media strategy	Media Strategy	Fully compliant		Comms Team	
Domain 8 - Cooperation										
42	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. These arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Signed mutual aid agreements where appropriate	Information is stored on the EPRR internal web page accessibale to all CHFT staff.	Fully compliant		Ian Kilroy	

43	Cooperation	Arrangements for multi-region response	Arrangements outlining the process for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs						
44	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and Public Health England will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency						
46	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders, during major incidents, critical incidents or business continuity incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation and the Civil Contingencies Act 2004 'duty to communicate with the public'.	CHFT are connected to WYAAT Emergency Planning Group, Kirklees Emergency Planning Group and Calderdale Emergency Planning Group. Equally, CCG led Group to review EPRR matters. THIS is also connected to the information principles	Fully compliant		Ian Kilroy		
Domain 9 - Business Continuity											
47	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continutiy Management System (BCMS) in alignment to the ISO standard 22301.	Y	Demonstrable a statement of intent outlining that they will undertake BC - Policy Statement	Overarching policy in place but out of date. Currently being reviewed. Internal Web Page designed. SRGG co-ordinates issues.	Partially compliant	BC Plan in place. Being reviewed and will be governed by the SRGG	Karen Bates		Currently under review.
48	Business Continuity	BCMS scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • Stakeholders	E-Learning BCMS package designed and available on the internal web page. Piloted at key services - ED, ICU, Medical Devices. Presentations delivered at variety of internal BC Exercises and shared on BCMS web page.	Fully compliant		Karen Bates		
50	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Statement of compliance	As required and led by THIS	Fully compliant		Karen Bates		
51	Business Continuity	Business Continuity Plans	The organisation has established business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	• Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation	Database is developed and internal to the shared drive for co-ordination purposes.	Fully compliant		Karen Bates		
53	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Audit reports	BC internal database designed and captures service identification and evidence based position.	Fully compliant		Karen Bates		
54	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectivness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• EPRR policy document or stand alone Business continuity policy • Board papers • Action plans	Multiple BC Exercises have taken place (Completed 31 Table Top/Drill/Simulation Based exercises thus far, since 2017). Post Exercise Reports are issued to service boards to action any identified changes. Monitoring of BCMS is governed through SRGG and routinely updated.	Partially compliant		Karen Bates		
55	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	Y	• EPRR policy document or stand alone Business continuity policy • Provider/supplier assurance framework • Provider/supplier business continuity arrangements	Liaison has taken place with Medical Devices, CHS/Equans regards developing their individual BC approach to clarify, challenge and qualify positions. Examples include BOC Medical Gases Exercise.	Fully compliant		Karen Bates		
Domain 10: CBRN											
56	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	IRP HAZMAT updates Remove, Remove, Remove. Drill Exercise evidences activity. Post Exercise Report highlights actions to be taken.	Fully compliant		Ian Kilroy		
57	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	YAS Audit planned in Aug 2019. Drill Exercise completed Jul 2019. Post Exercise Report produced. Planned a Multi Agency CBRNe durin March 2020 with YAS, WYFRS, WY Police. Internal EPRR HAZMAT Web Page set up for ED Staff, CHFT.Article in CHFT article - https://chft-weekly.cht.nhs.uk/viewIssue.php?issue=272&article=4517&prev=email. HAZMAT Working Group established.	Fully compliant		Ian Kilroy		
58	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	EPRR Database	Fully compliant		Ian Kilroy		

59	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	• Rotas of appropriately trained staff availability 24 /7	Staff management co-ordinated in ED, CHFT	Fully compliant		ED Staff		
60	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	• Completed equipment inventories; including completion date	Completed through ED CHFT Staff	Fully compliant		ED Staff		
62	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	• Record of equipment checks, including date completed and by whom. • Report of any missing equipment	ED Staff lead	Fully compliant		ED Staff		
63	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	• Completed PPM, including date completed, and by whom	Tent to be included for updated maintenance. Suits to be transferred ownership from NHS England to CHFT. Maintenance checks in place for Tent and Suits agreed by CHS/ISS. T&F Group established to review action plans. HAZMAT Audit shared with SRGG.	Fully compliant		Ian Kilroy		
64	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	• Organisational policy	Information is accessible, via the CHS Environmental Manager to assess the situation and make decision to dispose of equipment, as needed	Fully compliant		Ian Kilroy		
65	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	• Maintenance of CPD records	Initial training has targeted YAS, NARU and PRPS to educational facilitators and EPRR Lead. Additional sources are shared via internet, WYAT colleagues and CHFT internal web page. ED Training Lead staff have changed. Conversations with NHS England and YAS to develop the training elements. T&F Group re-established to develop and maintain current positions.	Partially compliant	T&F Group established. ED Facilitators have changed post the COVID era. HAZMAT Audit has taken place and distributed to NHS England in Jun 2021. ED Training package being reviewed by EPRR/HAZMAT ED Lead. NARU Suit training package received. EPRR HAZMAT internal web page developed further. Training packages to be agreed. Live/Practical Exercises to be agreed	ED Staff		
67	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	• Maintenance of CPD records	To identify present staff for an annual 'train the trainer' courses as previous staff trained now have left CHFT. NHSE/I developing the training package. Training for 2021/22 to be agreed. T&F Group established and received NARU additional training awareness information to be attached to EPRR HAZMAT internal web page.	Partially compliant	T&F Group established. ED Facilitators have changed post the COVID era. HAZMAT Audit has taken place and distributed to NHS England in Jun 2021. ED Training package being reviewed by EPRR Lead. NARU Suit training package received. EPRR HAZMAT internal web page developed further. Training packages to be agreed. Live/Practical Exercises to be agreed	ED Staff		

68	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	• Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • All service providers - see Guidance for the initial management of self presenters from incidents involving hazardous materials - https://www.england.nhs.uk/publication/eprr-guidance-for-the-initial-management-of-self-presenters-from-incidents-involving-hazardous-materials/ • All service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • A range of staff roles are trained in decontamination technique	Training Syllabus implemented. 40+ ED staff trained, via facilitators. YAS HAZMAT Audit in Aug 2019. YAS CBRN Self Assessment completed in Jun 2019 & 2021. Information shared with NHS England and CHFT HAZMAT T&F Group to be established to address the risks associated with delivery of response to a HAZMAT/CBRNe incident	Partially compliant	T&F Group established. ED Facilitators have changed post the COVID era. HAZMAT Audit has taken place and distributed to NHS England in Jun 2021. ED Training package being reviewed by EPRR Lead. NARU Suit training package received. EPRR HAZMAT internal web page developed further. Training packages to be agreed. Live/Practical Exercises to be agreed	ED Staff			
69	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		Completed	Fully compliant	IPC review provides compliance	ED Staff			

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
HART **Domain: Capability**										
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials • Chemical, Biological Radiological, Nuclear, Explosives (CBRNe) • Marauding Terrorist Firearms Attack • Safe Working at Height • Confined Space • Unstable Terrain • Water Operations • Support to Security Operations	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain HART tactical capabilities to the interoperable standards specified in the National Capability Matrices for HART.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National Training Information Sheets for HART.	Y						
H5	**HART**	**Protected training hours**	Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period i.e. training hours can be converted to live hours providing they are rescheduled as protected training hours within the seven-week period.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all HART personnel in their establishment. These records must include: • mandated training completed • date completed • any outstanding training or training due • indication of the individual's level of competence across the HART skill sets • any restrictions in practice and corresponding action plans.	Y						
H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered Paramedics.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times.	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must pass an initial Physical Competency Assessment (PCA) to the nationally specified standard.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any operational HART personnel returning to work after a period exceeding one month (where they have not been engaged in HART operational activity) must undertake an ongoing physical competency assessment (PCA) to the nationally specified standard. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard.	Y						

H12	**HART**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy HART resources at any live incident.	Y						
Domain: Administration										
H13	**HART**	**Effective deployment policy**	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H14	**HART**	**Identification appropriate incidents / patients**	Organisations maintain an effective process to identify incidents or patients that may benefit from the deployment of HART capabilities at the point of receiving an emergency call.	Y						
H15	**HART**	**Notification of changes to capability delivery**	In any event that the provider is unable to maintain the HART capabilities safely or if a decision is taken locally to reconfigure HART to support wider Ambulance operations, the provider must notify the NARU On-Call Duty Officer as soon as possible (and within 24 hours). Written notification of any default of these standards must also be provided to their Lead Commissioner within 14 days and NARU must be copied into any such correspondence.	Y						
H16	**HART**	**Recording resource levels**	Organisations must record HART resource levels and deployments on the nationally specified system.	Y						
H17	**HART**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their level of compliance with the HART response time standards. This must include an internal system to monitor and record the relevant response times for every HART deployment. These records must be collated into a report and made available to Lead Commissioners, external regulators and NHS England / NARU on request.	Y						
H18	**HART**	**Local risk assessments**	Organisations must maintain a set of local HART risk assessments which compliment the national HART risk assessments. These must cover specific local training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H19	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H20	**HART**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
H21	**HART**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.	Y						
H22	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
Domain: Response time standards										
H23	**HART**	**Initial deployment requirement**	Four HART personnel must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations.	Y						
H24	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised.	Y						
H25	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). A delayed response is acceptable if the live HART team is already deploying HART capabilities at other incident in the region.	Y						
H26	**HART**	**Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30 minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the 'on duty' HART team is already deployed at a local incident requiring HART capabilities.	Y						
Domain: Logistics										

H27	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment.	Y						
H28	**HART**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
H29	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable, and they subsequently receive approval from NARU for that local procurement.	Y						
H30	**HART**	**Fleet compliance with national specification**	Organisations ensure that the HART fleet and associated incident technology remain compliant with the national specification.	Y						
H31	**HART**	**Equipment maintenance**	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.	Y						
H32	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
H33	**HART**	**Capital estate provision**	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the National HART Estate Specification.	Y						
MTFA Domain: Capability										
M1	**MTFA**	**Maintenance of national specified MTFA capability**	Organisations must maintain the nationally specified MTFA capability at all times in their respective service areas.	Y						
M2	**MTFA**	**Compliance with safe system of work**	Organisations must ensure that their MTFA capability remains compliant with the nationally specified safe system of work.	Y						
M3	**MTFA**	**Interoperability**	Organisations must ensure that their MTFA capability remains interoperable with other Ambulance MTFA teams around the country.	Y						
M4	**MTFA**	**Compliance with Standard Operating Procedures**	Organisations must ensure that their MTFA capability and responders remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments.	Y						
Domain: Human Resources										
M5	**MTFA**	**Ten competent MTFA staff on duty**	Organisations must maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA Capability Matrix. Note: this ten is in addition to MTFA qualified HART staff.	Y						
M6	**MTFA**	**Completion of a Physical Competency Assessment**	Organisations must ensure that all MTFA staff have successfully completed a physical competency assessment to the national standard.	Y						
M7	**MTFA**	**Staff competency**	Organisations must ensure that all operational MTFA staff maintain their training competency to the standards articulated in the National Training Information Sheet for MTFA.	Y						
M8	**MTFA**	**Training records**	Organisations must ensure that comprehensive training records are maintained for all MTFA personnel in their establishment. These records must include: • mandated training completed • date completed • outstanding training or training due • indication of the individual's level of competence across the MTFA skill sets • any restrictions in practice and corresponding action plans.	Y						
M9	**MTFA**	**Commander competence**	Organisations ensure their on-duty Commanders are competent in the deployment and management of NHS MTFA resources at any live incident.	Y						
M10	**MTFA**	**Provision of clinical training**	The organisation must provide, or facilitate access to, MTFA clinical training to any Fire and Rescue Service in their geographical service area that has a declared MTFA capability and requests such training.	Y						

M11	**MTFA**	**Staff training requirements**	Organisations must ensure that the following percentage of staff groups receive nationally recognised MTFA familiarisation training / briefing: • 100% Strategic Commanders • 100% designated MTFA Commanders • 80% all operational frontline staff	Y						
Domain: Administration										
M12	**MTFA**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M13	**MTFA**	**Identification appropriate incidents / patients**	Organisations must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability. These procedures must be aligned to the MTFA Joint Operating Principles (produced by JESIP).	Y						
M14	**MTFA**	**Change Management Process**	Organisations must use the NARU Change Management Process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.	Y						
M15	**MTFA**	**Record of compliance with response time standards**	Organisations must maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU).	Y						
M16	**MTFA**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the MTFA capability to the these standards, the organisation must have a robust and timely mechanism to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the default in writing to their lead commissioners.	Y						
M17	**MTFA**	**Recording resource levels**	Organisations must record MTFA resource levels and any deployments on the nationally specified system in accordance with reporting requirements set by NARU.	Y						
M18	**MTFA**	**Local risk assessments**	Organisations must maintain a set of local MTFA risk assessments which compliment the national MTFA risk assessments (maintained by NARU). Local assessments should cover specific training venues or activity and pre-identified local high-risk sites. The provider must also ensure there is a local process to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) or a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
M19	**MTFA**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a MTFA deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
M20	**MTFA**	**Safety reporting**	Organisations have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.	Y						
M21	**MTFA**	**Receipt and confirmation of safety notifications**	Organisations have a process to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.	Y						
Domain: Response time standards										
M22	**MTFA**	**Readiness to deploy to Model Response Sites**	Organisations must ensure their MTFA teams maintain a state of readiness to deploy the capability at a designed Model Response locations within 45 minutes of an incident being declared to the organisation.	Y						
M23	**MTFA**	**10minute response time**	Organisations must ensure that ten MTFA staff are released and available to respond within 10 minutes of an incident being declared to the organisation.	Y						
Domain: Logistics										
M24	**MTFA**	**PPE availability**	Organisations must ensure that the nationally specified personal protective equipment is available for all operational MTFA staff and that the equipment remains compliant with the relevant National Equipment Data Sheets.	Y						
M25	**MTFA**	**Equipment procurement via national buying frameworks**	Organisations must procure MTFA equipment specified in the buying frameworks maintained by NARU and in accordance with the MTFA related Equipment Data Sheets.	Y						
M26	**MTFA**	**Equipment maintenance**	All MTFA equipment must be maintained in accordance with the manufacturers recommendations and applicable national standards.	Y						
M27	**MTFA**	**Revenue depreciation scheme**	Organisations must have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.	Y						

M28	**MTFA**	**MTFA asset register**	Organisations must maintain a register of all MTFA assets specified in the Capability Matrix and Equipment Data Sheets. The register must include: • individual asset identification • any applicable servicing or maintenance activity • any identified defects or faults • the expected replacement date • any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
CBRN **Domain: Capability**										
B1	**CBRN**	**Tactical capabilities**	Organisations must maintain the following CBRN tactical capabilities: • Initial Operational Response (IOR) • Step 123+ • PRPS Protective Equipment • Wet decontamination of casualties via clinical decontamination units • Specialist Operational Response (HART) for inner cordon / hot zone operations • CBRN Countermeasures	Y						
B2	**CBRN**	**National Capability Matrices for CBRN.**	Organisations must maintain these capabilities to the interoperable standards specified in the National Capability Matrices for CBRN.	Y						
B3	**CBRN**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that CBRN (SORT) teams remain compliant with the National Standard Operating Procedures (SOPs) during local and national pre-hospital deployments.	Y						
B4	**CBRN**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. Tactical and Operational Commanders must be able to access this advice at all times. (24/7).	Y						
Domain: Human resources										
B5	**CBRN**	**Commander competence**	Organisations must ensure their Commanders (Tactical and Operational) are sufficiently competent to manage and deploy CBRN resources and patient decontamination.	Y						
B6	**CBRN**	**Arrangements to manage staff exposure and contamination**	Organisations must ensure they have robust arrangements in place to manage situations where staff become exposed or contaminated.	Y						
B7	**CBRN**	**Monitoring and recording responder deployment**	Organisations must ensure they have systems in place to monitor and record details of each individual staff responder operating at the scene of a CBRN event. For staff deployed into the inner cordon or working in the warm zone on decontamination activities, this must include the duration of their deployment (time committed).	Y						
B8	**CBRN**	**Adequate CBRN staff establishment**	Organisations must have a sufficient establishment of CBRN trained staff to ensure a minimum of 12 staff are available on duty at all times.	Y						
B9	**CBRN**	**CBRN Lead trainer**	Organisations must have a Lead Trainer for CBRN that is appropriately qualified to manage the delivery of CBRN training within the organisation.	Y						
B10	**CBRN**	**CBRN trainers**	Organisations must ensure they have a sufficient number of trained decontamination / PRPS trainers (or access to trainers) to fully support its CBRN training programme.	Y						
B11	**CBRN**	**Training standard**	CBRN training must meet the minimum national standards set by the Training Information Sheets as part of the National Safe System of Work.	Y						
B12	**CBRN**	**FFP3 access**	Organisations must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent) and that they have been appropriately fit tested.	Y						
B13	**CBRN**	**IOR training for operational staff**	Organisations must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR).	Y						
Domain: administration										
B14	**CBRN**	**HAZMAT / CBRN plan**	Organisations must have a specific HAZMAT/ CBRN plan (or dedicated annex). CBRN staff and managers must be able to access these plans.	Y						
B15	**CBRN**	**Deployment process for CBRN staff**	Organisations must maintain effective and tested processes for activating and deploying CBRN staff to relevant types of incident.	Y						
B16	**CBRN**	**Identification of locations to establish CBRN facilities**	Organisations must scope potential locations to establish CBRN facilities at key high-risk sites within their service area. Sites to be determined by the Trust through their Local Resilience Forum interfaces.	Y						

B17	**CBRN**	**CBRN arrangements alignment with guidance**	Organisations must ensure that their procedures, management and decontamination arrangements for CBRN are aligned to the latest Joint Operating Principles (JESIP) and NARU Guidance.	Y						
B18	**CBRN**	**Communication management**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage and coordinate communications with other key stakeholders and responders.	Y						
B19	**CBRN**	**Access to national reserve stocks**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to access national reserve stocks (including additional PPE from the NARU Central Stores and access to countermeasures or other stockpiles from the wider NHS supply chain).	Y						
B20	**CBRN**	**Management of hazardous waste**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage hazardous waste.	Y						
B21	**CBRN**	**Recovery arrangements**	Organisations must ensure that their CBRN plans and procedures include sufficient provisions to manage the transition from response to recovery and a return to normality.	Y						
B22	**CBRN**	**CBRN local risk assessments**	Organisations must maintain local risk assessments for the CBRN capability which compliment the national CBRN risk assessments under the national safe system of work.	Y						
B23	**CBRN**	**Risk assessments for high risk areas**	Organisations must maintain local risk assessments for the CBRN capability which cover key high-risk locations in their area.	Y						
Domain: Response time standards										
B24	**CBRN**	**Model response locations - deployment**	Organisations must maintain a CBRN capability that ensures a minimum of 12 trained operatives and the necessary CBRN decontamination equipment can be on-scene at key high risk locations (Model Response Locations) within 45 minutes of a CBRN incident being identified by the organisation.	Y						
Domain: logistics										
B25	**CBRN**	**Interoperable equipment**	Organisations must procure and maintain interoperable equipment specified in the National Capability Matrices and National Equipment Data Sheets.	Y						
B26	**CBRN**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks coordinated by NARU unless they can provide assurance that the local procurement is interoperable and that local deviation is approved by NARU.	Y						
B27	**CBRN**	**Equipment maintenance - British or EN standards**	Organisations ensure that all CBRN equipment is maintained according to applicable British or EN standards and in line with manufacturer's recommendations.	Y						
B28	**CBRN**	**Equipment maintenance - National Equipment Data Sheet**	Organisations must maintain CBRN equipment, including a preventative programme of maintenance, in accordance with the National Equipment Data Sheet for each item.	Y						
B29	**CBRN**	**Equipment maintenance - assets register**	Organisations must maintain an asset register of all CBRN equipment. Such assets are defined by their reference or inclusion within the National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
B30	**CBRN**	**PRPS - minimum number of suits**	Organisations must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational.	Y						
B31	**CBRN**	**PRPS - replacement plan**	Organisations must ensure they have a financial replacement plan in place to ensure the minimum number of suits is maintained. Trusts must fund the replacement of PRPS suits.	Y						
B32	**CBRN**	**Individual / role responsible fore CBRN assets**	Organisations must have a named individual or role that is responsible for ensuring CBRN assets are managed appropriately.	Y						
Mass Casualty Vehicles										
Domain: Administration										
V1	**MassCas**	**MCV accommodation**	Trusts must securely accommodate the vehicle(s) undercover with appropriate shore-lining.	Y						
V2	**MassCas**	**Maintenance and insurance**	Trusts must insure, maintain and regularly run the mass casualty vehicles.	Y						
V3	**MassCas**	**Mobilisation arrangements**	Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents which may benefit from its deployment.	Y						
V4	**MassCas**	**Mass oxygen delivery system**	Trusts must maintain the mass oxygen delivery system on the vehicles.	Y						
Domain: NHS England Mass Casualties Concept of Operations										
V6	**MassCas**	**Mass casualty response arrangements**	Trusts must ensure they have clear plans and procedures for a mass casualty incident which are appropriately aligned to the *NHS England Concept of Operations for Managing Mass Casualties* .	Y						

V7	**MassCas**	**Arrangements to work with NACC**	Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) which will coordinate national Ambulance mutual aid and the national distribution of casualties.	Y						
V8	**MassCas**	**EOC arrangements**	Trusts must have arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving centres within the first hour of mass casualty incident.	Y						
V9	**MassCas**	**Casualty management arrangements**	Trusts must have a casualty management plan / patient distribution model which has been produced in conjunction with local receiving Acute Trusts.	Y						
V10	**MassCas**	**Casualty Clearing Station arrangements**	Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation.	Y						
V11	**MassCas**	**Management of non-NHS resource**	Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y						
V12	**MassCas**	**Management of secondary patient transfers**	Trusts must have arrangements in place to support some secondary patient transfers from Acute Trusts including patients with Level 2 and 3 care requirements.	Y						
Command and control **Domain: General**										
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the Standards for NHS Ambulance Service Command and Control.	Y						
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure to manage the incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS Ambulance Strategic Commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Service provider is responsible for ensuring that the provisions of the Command and Control Standards and Guidance including these standards are appropriately maintained. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
Domain: Human resource										
C5	**C2**	**Command role availability**	NHS Ambulance Service providers must ensure that the command roles defined as part of the 'chain of command' structure in the Standards for NHS Ambulance Service Command and Control (**Schedule 2**) are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Service providers must ensure that there is sufficient resource in place to provide each command role (Strategic, Tactical and Operational) with the dedicated support roles set out in the standards at all times.	Y						
C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Service providers must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions (i.e. the National Occupational Standards for Ambulance Command). This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						

C8	**C2**	**Contractual responsibilities of command functions**	Personnel expected to discharge Strategic, Tactical, and Operational command functions must have those responsibilities defined within their contract of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Service provider must ensure that each Commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Service provider must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
Domain: Decision making										
C11	**C2**	**Risk management**	NHS Ambulance Commanders must manage risk in accordance with the method prescribed in the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS Ambulance Commanders at the Operational and Tactical level must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	**C2**	**Command decisions**	NHS Ambulance Command decisions at all three levels must be made within the context of the legal and professional obligations set out in the Command and Control Standards and the National Ambulance Service Command and Control Guidance published by NARU.	Y						
Domain: Record keeping										
C14	**C2**	**Retaining records**	C14: All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	C15: Each Commander (Strategic, Tactical and Operational) must have access to an appropriate system of logging their decisions which conforms to national best practice.	Y						
C16	**C2**	**Access to loggist**	C16: The Strategic, Tactical and Operational Commanders must each be supported by a trained and competent loggist. A minimum of three loggist must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one Operational Commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for logs to be kept by a non-trained loggist should the need arise.	Y						
Domain: Lessons identified										
C17	**C2**	**Lessons identified**	The NHS Ambulance Service provider must ensure it maintains an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards.	Y						
Domain: Competence										
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the Strategic Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Strategic Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the Strategic Commander function must have successfully completed a nationally recognised Strategic Commander course (nationally recognised by NHS England / NARU).	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the Tactical Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Tactical Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the Tactical Commander function must have successfully completed a nationally recognised Tactical Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the Operational Commander function must have demonstrated competence in all of the mandatory elements of the National Occupational Standards for Operational Commanders and must meet the expectations set out in **Schedule 2** of the Standards for NHS Ambulance Service Command and Control.	Y						

C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the Operational Commander function must have successfully completed a nationally recognised Operational Commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements.	Y						
C24	**C2**	**Commanders - maintenance of CPD**	All Strategic, Tactical and Operational Commanders must maintain appropriate Continued Professional Development (CPD) evidence specific to their corresponding National Occupational Standards.	Y						
C25	**C2**	**Commanders - exercise attendance**	All Strategic, Tactical and Operational Commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. It could be the smaller scale exercises run by NARU or HART teams on a weekly basis. The requirement to attend an exercise in any 18 month period can be negated by discharging the role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties (as per the NOS) in their command role for incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any Strategic, Tactical and Operational Commanders that have not maintained the required competence through the mandated training and ongoing CPD obligations must be suspended from their command position / availability until they are able to demonstrate the required level of competence and CPD evidence.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Commander competence and CPD evidence must be assessed and confirmed annually by a suitably qualified and competent instructor or training officer. NHS England or NARU may also verify this process.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge the NILO /Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						
C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO /Tactical Advisor function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the NILO / Tactical Advisor discipline.	Y						
C30	**C2**	**Loggist - training**	Personnel that discharge the Loggist function must have completed a loggist training course which covers the elements set out in the National Ambulance Service Command and Control Guidance.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the Loggist function must maintain an appropriate Continued Professional Development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The Medical Director of each NHS Ambulance Service provider is responsible for ensuring that the Strategic Medical Advisor, Medical Advisor and Forward Doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the Standards for NHS Ambulance Service Command and Control).	Y						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the Medical Advisor or Forward Doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise every 12 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise.	Y						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (Strategic, Tactical and Operational) and the NILO/Tactical Advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in line with these principles.	Y						

C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors must be aware of the capabilities and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the NARU command guidance sufficient to enable the initial steps to be taken (e.g. notifying the Trust command structure and alerting mechanisms, following action cards etc.)	Y						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line responders are by default the first commander at scene, such staff must be aware of basic principles as per the NARU major incident action cards (or equivalent) and have watched the on line major incident awareness training DVD (or equivalent) enabling them to provide accurate information to control and on scene commanders upon their arrival. Initial responders assigned to functional roles must have a prior understanding of the action cards and the implementation of them.	Y						
JESIP										
Domain: Embedding doctrine										
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine (as specified in the JESIP Joint Doctrine: The Interoperability Framework) must be incorporated into all organisational policies, plans and procedures relevant to an emergency response within NHS Ambulance Trusts.	Y						
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	**JESIP**	**Five JESIP principles for joint working**	All NHS Ambulance Trust operational procedures for major or complex incidents must reference the five JESIP principles for joint working.	Y						
J4	**JESIP**	**Use of METHANE**	All NHS Ambulance Trust operational procedures for major or complex incidents must use the agreed model for sharing incident information stated as M/ETHANE.	Y						
J5	**JESIP**	**Joint Decision Model - advocate use of**	All NHS Ambulance Trust operational procedures for major or complex incidents must advocate the use of the JESIP Joint Decision Model (JDM) when making command decisions.	Y						
J6	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine.	Y						
J7	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that Commanders and Command Support Staff have access to the latest JESIP products, tools and guidance.	Y						
Domain: Training										
J8	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS Ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene. This must be refreshed and updated annually.	Y						
J9	**JESIP**	**Awareness of JESIP - control room staff**	NHS Ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets. This must be refreshed and updated annually.	Y						
J10	**JESIP**	**Awareness of JESIP - Commanders and Control Room managers / supervisors**	All NHS Ambulance Commanders and Control Room managers/supervisors attain and maintain competence in the use of JESIP principles relevant to the command role they perform through relevant JESIP aligned training and exercising in a joint agency setting.	Y						
J11	**JESIP**	**Training records - staff requiring training**	NHS Ambulance Service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						
J12	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command must have attended a one day, JESIP approved, interoperability command course.	Y						
J13	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e-learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J14	**JESIP**	**Commanders - interoperability command course**	Every three years, NHS Ambulance Commanders must repeat a one day, JESIP approved, interoperability command course.	Y						

J15	**JESIP**	**Participation in multiagency exercise**	Every three years, all NHS Ambulance Commanders (at Strategic, Tactical and Operational levels) must participate as a player in a joint exercise with at least Police and Fire Service Command players where JESIP principles are applied.	Y						
J16	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J17	**JESIP**	**Training - review process**	All NHS Ambulance Trusts must have an effective internal process to regularly review their operational training programmes against the latest version of the JESIP Joint Doctrine.	Y						
J18	**JESIP**	**JESIP trainers**	All NHS Ambulance Trusts must maintain an appropriate number of internal JESIP trainers able to deliver JESIP related training in a multi-agency environment and an internal process for cascading knowledge to new trainers.	Y						
Domain: Assurance										
J19	**JESIP**	**JESIP self-assessment survey**	All NHS Ambulance Trusts must participate in the annual JESIP self-assessment survey aimed at establishing local levels of embedding JESIP.	Y						
J20	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a METHANE message.	Y						
J21	**JESIP**	**Exercise programme - multiagency exercises**	All NHS Ambulance Trusts must maintain a programme of planned multi-agency exercises developed in partnership with the Police and Fire Service (as a minimum) which will test the JESIP principles, use of the Joint Decision Model (JDM) and METHANE tool.	Y						
J22	**JESIP**	**Competence assurance policy**	All NHS Ambulance Trusts must have an internal procedure to regularly check the competence of command staff against the JESIP Learning Outcomes and to provide remedial or refresher training as required.	Y						
J23	**JESIP**	**Use of JESIP exercise objectives and Umpire templates**	All NHS Ambulance Trusts must utilise the JESIP Exercise Objectives and JESIP Umpire templates to ensure JESIP relevant objectives are included in multi-agency exercise planning and staff are tested against them.	Y						

Ref	Domain	Standard	Detail	Evidence - examples listed below	Acute Providers	Self assessment RAG **Red (not compliant) =** Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Oxygen Supply **Domain: Oxygen Suuply**										
DD1	**Oxygen Supply**	**Medical gasses - governance**	The organisation has in place an effective Medical Gas Committee as described in Health Technical Memorandum HTM02-01 Part B.	•□Committee meets annually as a minimum •□Committee has signed off terms of reference •□Minutes of Committee meetings are maintained •□Actions from the Committee are managed effectively •□Committee reports progress and any issues to the Chief Executive •□Committee develops and maintains organisational policies and procedures •□Committee develops site resilience/contingency plans with related standard operating procedures (SOPs) •□Committee escalates risk onto the organisational risk register and Board Assurance Framework where appropriate •□The Committee receives Authorising Engineer's annual report and prepares an action plan to address issues, there being evidence that this is reported to the organisation's Board	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			
DD2	**Oxygen Supply**	**Medical gasses - planning**	The organisation has robust and tested Business Continuity and/or Disaster Recovery plans for medical gases	•□The organisation has reviewed and updated the plans and are they available for view •□The organisation has assessed its maximum anticipated flow rate using the national toolkit •□The organisation has documented plans (agreed with suppliers) to achieve rectification of identified shortfalls in infrastructure capacity requirements. •□The organisation has documented a pipework survey that provides assurance of oxygen supply capacity in designated wards across the site •□The organisation has clear plans for where oxygen cylinders are used and this has been discussed and there should be an agreement with the supplier to know the location and distribution so they can advise on storage and risk, on delivery times and numbers of cylinders and any escalation procedure in the event of an emergency (e.g. understand if there is a maximum limit to the number of cylinders the supplier has available) •□Standard Operating Procedures exist and are available for staff regarding the use, storage and operation of cylinders that meet safety and security policies •□The organisation has breaching points available to support access for additional equipment as required •□The organisation has a developed plan for ward level education and training on good housekeeping practices •□The organisation has available a comprehensive needs assessment to identify training and education requirements for safe management of medical gases	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			
DD3	**Oxygen Supply**	**Medical gasses - planning**	The organisation has used Appendix H to the HTM 0201 part A to support the planning, installing, upgrading of its cryogenic liquid supply system.	•□The organisation has clear guidance that includes delivery frequency for medical gases that identifies key requirements for safe and secure deliveries •□The organisation has policy to support consistent calculation for medical gas consumption to support supply mechanisms •□The organisation has a policy for the maintenance of pipework and systems that includes regular checking for leaks and having de-icing regimes •□Organisation has utilised the checklist retrospectively as part of an assurance or audit process	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			
DD4	**Oxygen Supply**	**Medical gasses -workforce**	The organisation has reviewed the skills and competencies of identified roles within the HTM and has assurance of resilience for these functions.	•□Job descriptions/person specifications are available to cover each identified role •□Rotating of staff to ensure staff leave/ shift patterns are planned around availability of key personnel e.g. ensuring QC (MGPS) availability for commissioning upgrade work. •□Education and training packages are available for all identified roles and attendance is monitored on compliance to training requirements •□Medical gas training forms part of the induction package for all staff.	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			
DD5	**Oxygen Supply**	**Oxygen systems - escalation**	The organisation has a clear escalation plan and processes for management of surge in oxygen demand	•□SOPs exist, and have been reviewed and updated, for 'stand up' of weekly/ daily multi-disciplinary oxygen rounds •□Staff are informed and aware of the requirements for increasing de-icing of vaporisers •□SOPs are available for the 'good housekeeping' practices identified during the pandemic surge and include, for example, Medical Director sign off for the use of HFNO	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			

DD6	**Oxygen Supply**	**Oxygen systems**	Organisation has an accurate and up to date technical file on its oxygen supply system with the relevant instruction for use (IFU)	•□Reviewed and updated instructions for use (IFU), where required as part of Authorising Engineer's annual verification and report	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			
DD7	**Oxygen Supply**	**Oxygen systems**	The organisation has undertaken as risk assessment in the development of the medical oxygen installation to produce a safe and practical design and ensure that a safe supply of oxygen is available for patient use at all times as described in Health Technical Memorandum HTM02-01 6.6	•□Organisation has a risk assessment as per section 6.6 of the HTM 02-01 •□Organisation has undertaken an annual review of the risk assessment as per section 6.134 of the HTM 02-01 (please indicated in the organisational evidence column the date of your last review)	Y	Fully compliant	Meeting took place between EPRR Lead and CHS (HRI) Equans (CRH) that govern the deepdive. 13 Aug 2021 between 1-2 pm.			

3. Calderdale and Huddersfield Solutions Managing Directors Report – December 2021

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

December 2021

Calderdale and Huddersfield Solutions Ltd
Huddersfield Royal Infirmary · Trust Headquarters ·
Acre Street · Huddersfield · HD3 3EA
Web: www.chs-limited.co.uk
Company registration number 11258001 · VAT number 293 0609 00

1.0 Company Update

Verbal Update

2.0 Service updates

2.1. Estates

2.1.1 Capital Development / Backlog

Construction works have commenced on the new Learning Centre at HRI, this is on the sub-basement corridor. Works are being phased to allow a decant of the office space, there is a delay to the programme due to finding asbestos containing materials and some additional fire compartmentation which became apparent as part of the refurbishment.

The demolition of the old Learning Centre and Nurses Residence is almost complete as per the photograph above. The car park will reopen as planned in early February. The former site will remain in Integrated Health Provider's (IHP) possession until the demolition and groundworks for the new Emergency Department (ED) are complete and any surplus spoil will be used to level the site. It is anticipated the site will be handed back to CHS in April/May allowing us to complete the wellbeing area to be funded via Trust charitable funds.

2.1.2 Community

Work to rationalise the estate footprint adjacent to HRI is now coming to an end. The disposal of 62 Acre Street is the last identified disposal. Lawyers have been appointed and the sale is due to complete this financial year. The transaction is with Assura who are working with the

GP Partners and CCG to develop a new GP practice on the site, after securing the Glen Acre House Car Park site last year.

2.1.3 LED Scheme
The LED scheme continues to progress at HRI albeit with challenges around timescales and delivery. The HRI programme is currently around 90% complete and is already saving both energy and money. The delays are access to areas due to operational activity, such as bed head lights and Intensive Care Unit (ICU).

2.1.4 Fire Safety
Fire safety remains an area of focus at HRI. Architects are in the process of surveying both HRI & Community Estate and drafting Fire Plans outlining recommended fire compartmentation lines. Following receipt of the drawings a site survey will be instructed and required works specified and tendered. A feasibility study for fire lifts has been commissioned and is due to be undertaken in early January. There will be an underspend on fire this financial year and finance have been made aware.

2.1.5 Portland Stone
A paper was presented to a subcommittee of programme transformation board with a recommendation to place the cladding solution on a hold until post reconfiguration due to operational pressures, whilst also ensuring mitigations are regularly reviewed.

2.1.6 Oxygen
The oxygen infrastructure became critical during the CV-19 peak. In particular, the monitoring of the Vacuum Insulated Evaporator (VIE). Monitoring became twice daily, and improvements were made during the peak which ensured the VIE operated as efficiently as possible. Demand peaked to 40% of the overall capacity during the first wave. We are now reporting on less than 18% which is near normal levels.

2.1.7 Ventilation
Additional air purifiers have been purchased to ensure air change levels are met when the new ED works commence early in the new year. This will allow us to seal windows on ward block 1 as per Infection Prevention Control (IPC) recommendations.

2.1.8 ED Development
The new ED scheme enabling works are on track, albeit with some delays caused by Virgin Media. The main demolition of Saville Court had been put back to earliest 15th December due to the diversion of fibres. A revised Gross Maximum Price (GMP) has been received and is currently being reviewed by CHS appointed cost advisors. The programme indicates a completion date of July 2023.

2.1.9 Learning & Development Centre CRH
Expressions of Interests were received by several modular contractors, procurement/estates & reconfiguration core team have prepared a mini competition tender which will be released imminently, with a deadline of mid-January with a view to appointing by the end of January 2022. The build is to be complete by Q1 2023, so we have very challenging timescales and are looking to commence demolition works early in the new year subject to planning.

2.2. Medical Engineering & Decontamination Service

2.2.1 Active Temperature Monitoring
Planned roll out and go live for the 17th January 2022, all reporting will on live system, with areas training compliance monitored weekly and reported into Matron meeting.

2.2.2 Decontamination contract

The BBraun surgical instrument decontamination contract is currently up for renegotiation, which has been instigated by BBraun the current position is that they want to see an 18.8% increase in base costs with the addition of a minimum service payment of 85%, which has not previously been the case. This would cause a significant cost pressure to each of the Pathfinder partners over the next 5 years. There are meetings being planned between the partners to agree a response to BBraun's proposal where the Finance leads will agree a percentage increase and then Procurement Leads will meet with BBraun to negotiate.

2.2.3 Decontamination planning for the future

As part of the Pathfinder group, we will be exploring the options for post May 2027 it is proposed that the following options will be explored:

- Continuing with the current provider.
- Switching to alternate provider.
- Taking on the current providers facility and delivering services as a group.
- Bringing service in house.

In order to complete the options appraisal would take a significant amount of time and resource, due to the value and complexity of the contract.

2.2.4 Patient Monitor replacement program

Theatres, Induction rooms, Recovery and High Dependency Unit (HDU) CRH are now all fitted out with GE (GE Company) monitors, we are now planning the ICU at HRI fitout for January 2022. Roll out of the monitors to Resuscitation at both sites and A&E Majors is being delayed due to staff training compliance level which is sitting at around 14%. ICU at CRH will be completed as capacity allows early 2022.

2.2.5 Development of Acute Respiratory Care Unit (ARCU)

ARCU future location will need to be planned into Reconfiguration for a move to the new build where it could have the requirements met for Medical Gas delivery, without incurring significant extra cost for the retrofitting of adequate O2 supply and ventilation into the Private Finance Initiative (PFI) site at CRH. Working closely with Respiratory Consultant's and Medical Division staff to develop a workable model to deliver from current location has been going well, but there is risk, which has meant that O2 concentrators have been sourced to ensure service delivery of O2 to patients on the other Ward, should ARCU O2 demand approach supply limits.

2.2.6 Healthcare Services Investigation Branch (HSIB) recommendations

With the release of the HSIB_Covid_19_breathing_equipment_safety_risk Medical Engineering have been exploring options with Respiratory to look at options to provide central monitoring of patients who are having CPAP therapy, initial thoughts were to redeploy the monitoring once recovered from ICU HRI & CRH, this would provide a short term lower cost fix, as the monitors & Central Station have already been in use for 8 of a proposed 10 year life span, this is not to say that they will not be supported, but it may become a factor in the future, which needs to be considered.

2.2.7 Training Compliance

CHS training compliance for Medical Devices for CHS remains above 95% and setting the standard for the Trust to follow. However, Trust compliance has remained fairly static overall.

Division	October	November
Surgical	64%	64%
Medicine	58%	58%
FSS	79%	78%
Community	72%	73%
Corporate	69%	66%
CHS	95%	97%
Trust	73%	73%

2.2.8 Initial Plans for Medical Engineering at CRH

We have put forward initial plans for Medical Engineering at CRH, these are now with Equans (was Engie, PFI Partner) and Service Performance for costing to renovate Ward 10. This should enable the hand back of Ward 9 to clinical use, prior to the end of March 2022.

2.2.9 Replacement and rollout of new pressure mattresses

At the request of Tissue Viability, we have started the release of the new Pure Air 8 Acute pressure Mattresses prior to reaching training compliance level of 70%, this has been done to relieve pressure on the existing stock and support patients with increasing requirements for pressure relieving devices, which has significantly increased over the last few weeks. This has been agreed with the caveat that it is raised by Corporate Division Tissue Viability lead as a risk.

2.2.10 KPI compliance

CHS Risk 7438 and CHFT Risk 7474 rating 20 relating to Medical Device Maintenance, although percentage compliance has increased for high and low risk categories medium has fallen slightly this month. We expect to see a significant improvement once the decommissioning of many assets is completed that have not been presented/identified/or a plan put in place for maintenance. this is in line with the plan presented to Medical Device Procurement & Management Group, to mitigate this risk within target date, which was agreed:

Compliance reports for Divisions have been provided monthly, which identify areas with outstanding work.

Green will require.

- >95% High Risk assets.
- >90% Medium Risk.
- >85% Low Risk.

Amber will be.

- 90% to 95% High.
- 85% to 90% Medium.
- 80% to 85% Low.

Red will be.

- <90% High.
- <85% Medium.
- <80% Low.

2.2.11 Student Placements/volunteer

We were unable to secure the third placement, however we have been engaging with a potential volunteer who has expressed a wish to gain experience prior to continuing studies on their master's degree.

2.2.12 Observations into EPR (S4S)

We have completed a successful trial of the system proving the Wi-Fi connectivity and passage of information to Nerve Centre, as part of this trial a time and motion study was completed, which showed a 10.4 second improvement on the manual process, without any prior training on the system, with the added benefit of verification of patient information and the proving of escalations process, when abnormally high SPO2 (oxygen saturation) and Heart rate readings were injected into the system by using our test equipment to simulate out of range readings for NEWS score, the alert and escalation message were produced in Nerve Centre and could be accepted on the Zebra device and remained until actioned.

2.2.13 Exploring SLA with Barnsley

We looking to put in place an SLA to deliver Medical Engineering Services in support of Barnsley wholly owned subsidiary to maintain some of their Trust assets.

2.3. Facilities

2.3.1 Covid Support

Facilities services have further been able to step down some of the additional services, which we have been providing over the past 18 months. There are only a couple of areas within cleaning services which are being approved on a month-by-month basis.

2.3.2 Laundry Tender

The laundry tender process is now in its final stages with the “intention to award” letter at the checking off point with the legal team. We are still awaiting a start date and a contract extension has been put in place, in the interim

2.3.3 Retail catering

The new retail outlets are all now open with final bits of snagging works to be undertaken. We have received very good positive feedback regarding the Southside Dining food. Areas will see changes to the sandwich provision as we moved to a new provider on 6 December 2021. We have appointed a Commercial retail manager which has left us with high hopes as the person in question has a vast retail knowledge after managing several WH Smith stores for almost 30 years

2.3.4 Enhanced shuttle service

Plans have been put on hold with regards to a start date for the park and ride service, which will run from Broad Street Plaza to CRH. This is down to budget pressures. Preparation work will hopefully recommence in Spring 2022

2.3.5 Staffing

Staffing remains challenging because of long-term sickness, inability to recruit, and covid related conditions such as self-isolation or returned shielders, who are unable to carry out full duties. Whilst Domestic services remain the worst affected service, there has been a slight improvement in numbers returning to work.

2.3.6 National Cleaning Standards

Work is ongoing with the New NHS Cleaning Standards, with training planned for all Housekeepers. Nursing staff will receive online training in ESR. The plan is to have everything in place for January / February so that any tweaks / changes can be done before “Go Live” in May 2022.

2.3.7 BICS (British Institute of Cleaning Science)

Training has been slow during the past few weeks due to Appraisal season and mandatory training, therefore the dept has only seen a small increase of staff receiving the training. The service manager is confident that the whole of the department will be trained by the March 2022 deadline.

2.4. Procurement

2.4.1 Materials Management

November and December 2021 have been incredibly challenging for the team again due to planned annual leave, long term sickness (HRI) and medical issues affecting two members of staff that are on light duties only. Daily Personal Protective Equipment (PPE) provision is increasing in volume in line with clinical demand along with lateral flow test requests for distribution. The PPE dedicated bank staff member has also left the team this month.

NHS Supply Chain (NHSSC) / West Yorkshire Association of Acute Trusts WYAAT:

- Multiple daily national stock outs or supply disruptions of products have impacted materials management negatively with the core service taking twice as long.
- Lack of cages in the system have affected deliveries to Cleaning Services which have arrived on pallets.
- Further WYAAT work plan projects have been identified and include minimally invasive consumables, a sustainability switch to waste cardboard containers and interest from the wider ICS to collaborate with the Clinical Subgroup. All potential projects have been sent to Category Towers for scoping. (pre-agreed contracts via NHSSC which we can make purchases from)

Scan4Safety:

- Tentative go live date has been pushed to the 19th January 2022 in Elective Surgery Unit (ESU), HRI. This is down to uncertainty that ESU will be ready for then.
- Handheld scanners have arrived, and a session was provided on the 9th December in ESU for the clinical staff to see the devices in action.

2.4.2 Category Management

Hazel Brauner started her role as e-Commercial and Contract Officer on 15th November 2021 moving from the Buying Team. Hazel is currently focussing on the implementation of the Health Family e-Commercial Solution – Atamis. The priority is to create and maintain a contract register for all Live contracts across CHS and the Trust. From 15th November 2021 to date Hazel, the Category Team and the Buying Team have created 122 contract records which include as a minimum a copy of the signed contract along with any procurement related documentation and purchase orders. As the contracts are managed in the Business Units, the information is sometimes very limited as the information is not always available, this will improve over time as the Procurement Team implement the contract management module of Atamis and maintain all contract records in the future. Atamis will become the main toolkit for all procurements, contracts, and supplier management. We are currently in the lead across WYAAT for the highest number of contract records within Atamis.

The team are currently experiencing an extremely high volume of procurement requests which is putting pressure on the team, meaning urgent or high-risk projects that have approved funding will take priority. Two Assistant Category Managers are currently working on 192 Maintenance contracts and 210 Leasing contracts, both are undertaking a piece of work with the relevant stakeholders and suppliers to rationalise contracts where possible.

As well as Reconfiguration, the team have several major projects that they are leading on such as the procurement of the replacement beds, replacement of 120 defibrillators, multi-contract supply of insulin pumps and outsourcing Ultrasound services to name a few.

The Procurement Team have made fantastic progression with the efficiency savings.

	Sum of Q1	Sum of Q2	Sum of Q3	Sum of Q4	Sum of Total
Cash release	**61,794**	**133,440**	**181,764**	**184,600**	**561,599**
Non-Recurrent	500	19,720	6,483	6,483	33,186
Recurrent	61,294	113,720	175,281	178,117	528,413
Cost Avoidance	**274**	**136,883**	**157,587**	**157,587**	**452,331**
Non-Recurrent	274	15,461	35,136	35,136	86,007
Recurrent	0	121,422	122,451	122,451	366,324
Grand Total	**62,068**	**270,323**	**339,351**	**342,187**	**1,013,930**

Following a benchmarking exercise, we have changed the way we procure ICT Hardware as the benchmarking has shown we can achieve some great savings. One example is we procured laptops using the CCS Digital Marketplace portal and saved £1000 on our “go to” incumbent’s quotation.

2.4.3 Operational Procurement

The team continue working as part of the catering project. The team are providing support post go live to stakeholders and continue to deal with queries and support the project team as necessary.

The prescription eyewear contact went live in November which will enable staff to receive prescription eyewear to allow them to conduct their duties safely and with the correct PPE.

We are currently working with Ophthalmology for bespoke face shields, the prototype has been delivered and with the stakeholder and IPC for review.

The team have been supporting on the reconfiguration project and will be involved in the procurement workstream to deliver the procurement activity for the Reconfiguration programme. The team work to finalise the equipment list needed for ED including what existing equipment can be transferred from the existing site to the new ED. We have also been involved in the car park pre works orders relating to surveys etc. The team will continue to support this project as necessary.

We are involved in the Display Screen Equipment (DSE) home worker assessment group to provide product and pricing information to inform the group moving forward. We have recently taken on the Technology Digital Procurement Project to help streamline the procurement process and ensure that the Trust/CHS is compliant when procuring technology products and services. We are trialling two new portals provided by North of England Commercial Procurement Collaborative (NOECPC) and the CCS Technology Purchasing Platform. This allows us to receive product and pricing information in real time, reducing the need to request quotes on multiquote which can take 2-3 days for responses. It also ensures compliance as these are contracted items and has already achieved some savings even during trials. We will continue to test and review and look to roll out across the department.

We continue to carry out housekeeping exercises to reduce accruals prior to financial month end close down and are working on actioning invoice queries in collaboration with Accounts

Payable (AP) to work towards Public Sector Payment Policy (PSPP) targets. We have implemented a new way of dealing with urgent invoices which has been trialled throughout November. This should reduce email traffic between the AP/Procurement teams and aide efficiency.

The Scan4Safety project continues to progress, we have submitted catalogue data for wave 1 suppliers, and this has been reviewed by Leeds Teaching Hospitals (LTH) in preparation for the roll out of the Inventory Management Solution. LTH have confirmed they are 100% of the way through the data and this has been loaded into the test system. We are currently working on the interface between the IMS System, SupplyX, and the Electronic Patient Record (EPR) system, NEP Oracle Cloud, which will allow requisitions to be automatically generated as products are issued by the department. We have had the first two test orders successfully complete this week and further testing is underway and will continue over the next weeks in preparation for roll out. ESU is currently the planned first area for deployment and discussions are ongoing to identify go live date.

We have recently appointed internally to the position of B4 Buyer and the successful candidate has been in post since 15th November 2021. We have interviewed for a B2 Assistant Buyer to backfill the successful candidate and have appointed an internal candidate from Materials Management with a start date of 17th January 2022. Interviews are set for the B3 Data Officer (Scan4Safety) position on 10th December, and we hope to have the position filled with a start date of early January. We currently have the two vacant positions and sickness absence within the team meaning it is currently very challenging however the team are working hard to continue providing essential services to CHS and the Trust.

3.0 CHS

3.1. Spotlight Awards

October

Stephen Peterson was nominated by Rob Ross for improving patient safety and compliance of high-risk medical devices, Stephen was solely responsible for driving and achieving a compliance level of 94.9% on high-risk medical devices at HRI site, this was due to his focused effort, determination, and engagement with Trust staff.

November:

Lynsey was nominated by Kel Sanders. Lynsey joined the Catering Project Team to gain experience of working on a project. Lynsey has worked very closely with the project team, in particular Adrian Brown in Facilities, to ensure that everything required to be in sourced for 'go live' (equipment, consumables etc) on 1st November 2021 was correctly scoped, ordered, delivered on time and within budget. There was a situation whereby a piece of equipment was delivered that was incorrect. However, due the equipment being held in storage for over a month, we had passed the deadline for returns. Lynsey successfully negotiated the return and replacement of this equipment, saving CHS from having to pay additional money for a replacement or invalidating the warranty by amending the equipment to make it fit for purpose. Due to the nature of the consumables being sourced (food, drink, confectionery etc) approximately 35 orders could not be placed until the Monday before go-live. After processing only 5 of these orders, Lynsey fell down the stairs and broken her thumb. Before seeking medical help (unbeknownst to the team) Lynsey continued to process the remaining orders to ensure they were received in time prior to going to A&E to get x-rayed and strapped up (she is recovering well now).

3.2. Finance

Month 8 - October 2021

The month 8 position reports a £0.05m surplus against a plan of £0.07m with a £0.02m adverse variance. This position results from the over recovery of income (£2.24m) due to an increase in the goods and services being transacted through the company offset by an under spend on pay (£0.05m) (favourable to plan) and overspend on non-pay (£2.30m) (adverse to plan). Total income is above plan by £2.24m which reflects the increase in income invoiced for goods and services requested by CHFT. Pay is underspent £0.05m due to vacancies in Senior positions offset by variations requiring additional staffing in domestic and portering

services. Non pay is overspent by £2.30m due to an increase in goods and services being transacted through the company.

Year To Date

The month 8 YTD position reports a £0.53m surplus against a plan of £0.54m with a £0.01m adverse variance. This position results from the over recovery of income £12.47m (favourable to plan) due to an increase in the goods and services being transacted through the company offset by an overspend on non-pay £12.55m (adverse to plan). Pay shows a variance of £0.07m (favourable to plan) due to additional staffing resources required to deliver services in response to COVID 19, this is offset by vacancies in Senior Positions and through funded variations agreed with CHFT. Non pay is overspent by £12.55m due to an increase in goods and services being transacted through the company. Total income is above plan by £12.47m which reflects the increase in income invoiced for goods and services requested by CHFT.

Forecast 2021/22

The year-end forecast shows a £0.06m adverse variance to plan.

Capital 2021/22

The month 8 position reports a £1.0340m underspend to plan in main due to the deferment of the Learning centre development to Autumn of this year (£375k). The year-end position is forecast to be within plan.

CIP 2021/22 Estates and Facilities

The target for CHS is £795k. At this stage schemes of £344k have been identified as recurrent relating to energy and waste and are at gateway 2. Managers and Heads of Service are currently working on efficiency plans to deliver the target in conjunction with CHFT.

CIP 2021/22 Procurement

The target for CHS is £750k. At this stage schemes of £388k have been identified as recurrent relating to NHS supply chain and maintenance contracts and are at GW2. A plan has now been worked up with forecast savings of £559k for the end of the year. The team continue to deliver cost avoidance schemes of £452k.

3.3. Workforce

3.3.1 Attendance

CHS Sickness rate for October is 6.75% comprising long term sickness 4.76% and short term sickness 1.99%. This is a reduction in last month's figure of 7.03%. Each case has an individual management plan and specific absence support sessions have taken place with managers and will continue as required.

3.3.2 Appraisal and Essential Skills Training

Mandatory training is green at 90% + in all areas with the exception of data security. A list of non-compliant staff has been issued to managers in this respect.

Appraisal season has not been extended formally for CHS colleagues however there has been a month’s grace period till the end of November for these to be finalised. There are 21 completed appraisals from one department that were not recorded on Electronic Staff Record (ESR) at the time of reporting. These are now on the system and will reflect in next month figures. Managers are reminded of the outstanding information and support is being provided with inputting the data onto ESR following the appraisal conversation. Compliance stands at 85.6% with 334 of 389 eligible colleagues having an appraisal within the current financial year.

3.3.3 Staff Survey

The staff survey closed on 26 November 2021. The response rate at that time was 47.0% *(206 respondents from an eligible sample of 438 staff)*. The final percentage will not be confirmed by the survey provider Picker, until after the close of fieldwork. Last year’s response rate was 50%.

3.3.4 Retail Services – TUPE (Transfer of Undertakings Protection of Employment) Transfer of Staff

Compass staff formally transferred to CHS on 1 November 2021.

The HR obligations of the TUPE transfer are complete and 1:1 meetings have now taken place with staff to welcome them to the organisation and conduct the necessary identity checks required under the transfer of undertakings legislation.

3.3.5 Leavers

There are a higher-than-average number of leavers during October 2021. Whilst initially concerning, following a review of reasons for leaving these are as follows: 1 probationary period dismissal/1 performance management resignation/4 age retirements/1 returned to university/1 promotion (external)/1 also runs own business -work life balance /1 CHS Terms and conditions (charge hand porter)/1 apprenticeship to HCA.

4.0 KPIs

CHS provide 60 key performance indicators (KPIs) to CHFT of which just 4 **did not** achieve Green Target.

- **Estates -** % of reactive calls completed within timescales **– AMBER 62.74%** against a target of >70%
- **Estates –** Statutory PPMs carried out within agreed timescales **– RED 89.80%** against target of 100%**.**
- **Medical Engineering -** Medium Risk PPMS – **AMBER – 60.70%** against target of >70%.
- **Medical Engineering -** Low Risk PPMS – **AMBER – 59.38%** against a target of >60%

5.0 Risks

An overview of CHS high level risk register is included within Appendix 1.

The very high / high risks that CHS seek to manage and mitigate are:

- HRI Estates failing to meet minimum condition due to age and condition of the building (20)
- Resus – Collective risk to maintain compliance / upgrade (20)
- ICU – Collective risk to maintain compliance / upgrade (20)
- Medical Engineering - There is a risk of equipment failure from Medical Devices on the current trust asset list (20)
- Fire safety due to breaches in compartmentation, and a lack of compartmentation in some areas, and enough staff trained in fire safety awareness and as fire wardens (in CHFT) (15)
- The façade of HRI (15).
- **NEW** for October – Reduced oxygen flow rate & pressure drop Ward 11, HRI (16)

6.0 Recommendation

The Board is asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – December 2021

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	4	0
Red Risks High	3	0
Amber Risks Moderate	29	+2
Green Risks Low	9	0
Total	45	+2

Risk ref + score	Strategic Objective	Risk	Executive Lead	July 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21
CHS Risk 6903 (CHFT 7444 (12)	Keeping the base safe	Resus – Collective risk to maintain compliance / upgrade	Managing Director (SS) Head of Estates (TD)	=20	=20	=20	=20	=20	=20
CHS Risk 7271 (CHFT 7442 (12)	Keeping the base safe	ICU – Collective risk to maintain compliance / upgrade	Managing Director (SS) Head of Estates (TD)	=20	=20	=20	=20	=20	=20
CHS Risk 5806	Keeping the base safe	Overall condition of the building –There is a risk to areas due to the age, environment and condition of the HRI building.	Managing Director (SS) Head of Estates (TD)	=20	=20	=20	=20	=20	=20
CHS Risk 7438 (CHFT 7474 (15)	Keeping the base safe	There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5369) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time.	Manager Director (SS) Head of Medical Engineering (RR)	=20	=20	=20	=20	=20	=20
CHS Risk 8133	Keeping the base safe	There is a risk of: A reduced oxygen flow rate and pressure drop due to the oxygen infrastructure to ward 11. Caused by: Ward 11 only has one oxygen outlet per 2 beds, meaning a decision has to be made on which bed can receive high flow oxygen. Resulting in: One bed or several beds having no oxygen supply	Managing Director (SS) Senior Estates Officer (DS)				=16	=16	=16
CHS Risk 7318 (CHFT 7414 (15)	Keeping the base safe	There is a risk to life and building due to the failed / heavily corroded metal ties that hold back the Portland Stone cladding at HRI, particularly Ward Black 1 South Elevation potentially resulting in falling Stone debris.	Managing Director (SS) Head of Estates (TD)	=15	=15	=15	=15	=15	=15
CHS Risk 5511 (CHFT 7413 (15)	Keeping the base safe	Collective Fire Risk – There is a risk of increased fire spread and delayed evacuation at HRI	Managing Director (SS) Head of Estates (TD)	=15	=15	=15	=15	=15	=15

The Risk Register has been noted by CHS Board.

4. Board Sub-Committee Minutes in the Review Room

- Finance and Performance Committee – 04.10.21, 01.11.21 & 29.11.21
- Quality Committee – 11.10.21 & 08.11.21 & 06.12.21
- Workforce Committee – 08.11.21 & 06.12.21
- Charitable Funds Committee - 22.11.21

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Monday 4 October 2021, 11.00am – 13.00pm Via Microsoft Teams

PRESENT

Richard Hopkin	Non-Executive Director (Chair)
Kirsty Archer	Acting Director of Finance
Anna Basford	Director of Transformation & Partnerships

IN ATTENDANCE

Suzanne Dunkley	Director of Workforce & Organisational Development
Jonathan Hammond	Director of Operations - Medicine
Peter Keogh	Assistant Director of Performance
Philip Lewer	Trust Chair
Andrea McCourt	Company Secretary
Jim Rea	Managing Director – Digital Health
Philippa Russell	Assistant Director of Finance
Thomas Strickland	Director of Operations - Surgery
Linda Cordingley	EA to Chief Executive (Minutes)

A quorum was not established as only 3 of the 4 required members were present, though there was representation by 3 colleagues on behalf of the COO. Due to the absence of a quorum, approval of the minutes will take place at the next full Committee meeting on 1 November 2021.

ITEM

143/21 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

144/21 APOLOGIES FOR ABSENCE

Apologies were received from Stephen Baines, Gary Boothby, Peter Wilkinson and Owen Williams.

145/21 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

146/21 MINUTES OF THE MEETING HELD 31 AUGUST 2021

The minutes of the meeting held 31 August were **APPROVED** as an accurate record.

147/21 COLLEAGUE AVAILABILITY DEEP DIVE

The Director of Workforce & Organisational Development provided an update of the current staffing position, showing comparisons across the WY&H patch and the anticipated trajectory. The steps to improve availability in hot spot areas (which were impacting on patient flow) were noted. As at 24 September 2021, 21.4% of the workforce was unavailable with a mix of Covid-19 absence, annual leave, study leave and isolation absence, give a 4.76% rolling absence. The total absence for August was 5.69%, with an expected 6.23% October peak and 6.8% in January 2022 (following the same pattern as previous years). It was noted that return to work interview compliance had deteriorated to 60%. 14% of the bed base was now Covid-19 patients. As at 24 September 2021

there were 55 colleagues isolating with a further 37 absent due to Covid-19, 82.1% of which were clinical colleagues - Band 2s, 51-60 year olds, female, white. Patient-facing areas were experiencing anger from patients. The focus on getting and keeping colleagues well remained, raising the profile of health and wellbeing and ensuring the wellbeing hour was supported. There was evidence that GPs were signing off colleagues for longer periods impacting further on availability therefore it was important to actively manage absence processes. WoD colleagues were stepping in to support managers so that colleagues could be moved in a planned and positive way. A wellness passport was being trialled in Medicine, with spot checks on the wellbeing hour, breaks and management of annual leave. It was important to communicate our plan to colleagues and support was being sought from CCGs in communicating with GPs.

There was concern that our sickness performance was deteriorating on a regional basis, CHFT having moved from 5th best to 4th bottom across NE&Y and NW. This is in the context of the high and rising number of Covid-19 patients (currently 90), particularly as we moved towards winter. It was recognised that there were peaks in annual leave, particularly during school holidays and potentially at Christmas. The Acting Director of Finance said it was important to cross reference this with the financial position as this was closely linked to the emergency decision taken during the summer to increase our enhancement to the bank pay rate to 50% to improve staffing availability, which was costing £800k per month. The initial four-week period had been retained for the time being whilst the benefits and effectiveness were assessed. The current thinking was to have a more targeted approach for the premium to address areas where there were real concerns (hot spot areas) balanced with affordability given the pressure on the financial position. A further update would be made at the next meeting following a review and decision by the Executive Board.

The Committee **RECEIVED** and **NOTED** the colleague availability deep dive update.

148/21 **ACTION LOG AND MATTERS ARISING**

The Action Log was reviewed as follows:

149/20:138/20 – Stroke Deep Dive

The Director of Operations (Medicine) presented a deep dive into Stroke services. Further to the June 2021 presentation in response to concerns over some of the Stroke performance metrics, i.e. 4 hour admission/percentage spending 90% of stay on the Stroke Unit, 7 key actions with timelines had been identified. It was noted that the SSNAP score was A for April-June 2021, although access to the Stroke Unit (at D) continues to be a challenge. There had been an improvement in the 90% target in August but still remained at E. In 2019-20 there had been a 17% increase in the number of potential stroke patients presenting in ED. In January 2021 there had been a 36% increase. There were more disabled stroke patients which made discharge challenging. Acuity had increased which was impacting on length of stay (LoS). In 2019 the LoS was 4-12 days and in 2021 it was 8-18 days. The actions to maintain and improve performance were noted – a business case to improve access to a

stroke bed would be completed by the end of October 2021, to build the resilience needed around Covid-19 peaks, taking into account work undertaken at Pinderfields (it was noted that although MY had seen some improvements it was still not achieving the 4 hour target due to the impact of Covid-19). There was space currently available on the Stroke floor and a large capital investment was not envisaged. The Division was currently working through the staffing requirements and flow.

A breakthrough event of the stroke pathway had taken place with Executives, with a further event scheduled in October, where late presentation and outcomes would be raised.

It was noted that although ED attendances were increasing, actual admissions had reduced. It was recognised that the front end needed support but an overall model to support patient flow throughout the whole pathway was required. The Acting Director of Finance advised that higher acuity should be noted by commissioners (CCGs prior to April 2022 and ICS thereafter) and may be beneficial in terms of support with the business case. A further update would be provided in 2022.
ACTION: A further update would be provided in February/March 2022.

122/21 – Efficiency Engagement Project – (covered under item 150/21)

069/21:059/21 – Financial Planning Guidance – (covered under item 150/21)

149/21 BOARD ASSURANCE FRAMEWORK (BAF)

The Company Secretary updated the Committee regarding the BAF risks which had Committee oversight. Risk 5/20 – Covid-19 capacity and delays for non-Covid patients – to be raised from 16 to 20. This was due to the position not improving and CHFT being more impacted than neighbouring organisations and nurse staffing availability issues. The BAF risk against commercial income generation was also discussed and it was decided that following receipt of the HPS financial recovery plan at the recent HPS Board meeting this risk would be maintained at the current level and kept under review.

The Committee **APPROVED** the increase in the risk rating.

The Committee **NOTED** that the current risks in HPS and THIS (commercial income) would remain at the current level.

FINANCE & PERFORMANCE

150/21 MONTH 5, FINANCE REPORT (INCLUDING HIGH LEVEL RISKS & EFFICIENCY PERFORMANCE)

The Acting Director of Finance highlighted the key points reported at Month 5, showing a challenging underlying position of a £2m overspend. Additional elective recovery funding (ERF) relating to Month 2 had been received (ERF was received in the first 3 months but the costs hit in the second 3 months). The enhanced pay offer had caused significant pressure in month and the costs of recovery and Covid-19 were increasing. A break-even position was forecast

by the end of September 2021. It was expected that the earlier ERF benefit would be taken up in the remainder of H1, therefore the position would be more challenging as the months progressed, therefore there would be a need for greater efficiencies. It was noted that there was an increase in the aged debt at the end of Month 5 due to an outstanding invoice to Health Education England (HEE). This had now been resolved. The capital position showed an underspend at the end of the month which was anticipated therefore capital plans for the remainder of the year had been reframed with externally funded capital project slippage to next year. The capital picture would change significantly following receipt of the financial planning guidance and the Targeted Investment Funding available.

The Committee **RECEIVED** and **NOTED** the Month 5 finance report.

122/21 - Efficiency Engagement Project
An overarching approach to efficiency was being considered which would take into account the traditional CIP transformation, GIRFT, reconfiguration efficiencies, the recovery agenda, gains from productivity, BREEAM and the wider economic and social benefits. A new set of governance arrangements would be put in place. Routine savings over the next 6 months were being considered with a more detailed programme for 2022/23. In terms of H2 financial plans the timetable would be challenging.

069/21:059/21 - Financial Planning Guidance
The guidance had been received covering October 2021 to March 2022. The NHS settlement was an additional £5.4bn, which included £1.5bn recovery funding for electives and cancer. There would be £1bn for ERF with new targeted investment funding (TIF) of £0.5bn plus £0.2bn of flexible capital or revenue. The ICS system would receive £32m with CHFT's share being £6.4m. The deadline for the return to the ICS of the Place-based activity and performance submission was 11 October 2021 to meet the ICS submission deadline of 14 October 2021. The whole system package would be required by 16 November 2021 and provider finance plan submissions by 26 November 2021. The efficiency for H2 was 0.82% compared to 0.28% in H1. There was a further targeted reduction in Covid-19 funding (-6.2%) with non-NHS income at 75% of H1 support. There was new additional capacity funding for non-electives of £14.2m for the system to cover winter pressures, etc. outside of recovery and Covid-19. ERF would be funded at the same level despite the change in thresholds. Any H1 surplus or deficit could be carried forward to H2.

The system approach, as opposed to organisational approach, was recognised. The combined reductions to funding are likely to generate an overall 2% efficiency target. The ICS level funding would be influenced by how far an organisation was away from target, therefore there was a risk that this could be distributed across organisations already in receipt of support (including CHFT). In terms of the ERF and targeted independent sector (IS) allocation for outsourcing it could not be automatically assumed that if we commit to costs over 19/20 levels funding would follow as it would be measured at ICS level. It was noted that the financial plans would need Board approval in November 2021 therefore would be considered at this Committee prior to 4 November 2021.

ACTION: The H2 financial plan to be submitted to the November meeting.

151/21 INTEGRATED PERFORMANCE REVIEW – AUGUST 2021

The Assistant Director of Performance reported that the Trust's performance for August 2021 was 70.4%, a small deterioration compared to July. The following key points were highlighted:

There had been a slight deterioration in the Friends & Family test for A&E and Community. It was noted that new national targets were being introduced from September. There were also concerns around the timeliness of complaint responses.

Safe/Caring – it was noted that there were staffing concerns, particularly in theatres, on elderly care wards, the Stroke Unit and Wards 6AB at CRH. A "worry area" dashboard would be monitored by Gold Command. There had been an increase in the number of complaints and the ability to respond in a timely manner. There had been an increase in falls but good performance overall.

Effective – it was noted that there were new IPC targets with MRSA screening being challenging around data quality capture. #NOF challenges were being addressed. SHMI was below 100 although being closely monitored going forward.

Responsive – it was noted that there were high volumes of attendances in ED, high acuity and occupancy levels. However, CHFT was still in the upper quartile nationally and across WY. Cancer performance was good and plans were in place to improve screening and the 38day position. The Assistant Director of Performance was working with our NEDs to develop key metrics to discuss at the Board Development session on 7 October 2021 to provide focus on areas of concern for NEDs and Executives. It was noted that theatre utilisation remained challenging. The Director of Operations (Surgery) advised that there had been layout changes to the management of day case and complex cases which was interrupting the smooth flow when patients presented from wards or walk-ins from the day surgery unit. Additional consenting rooms were being put in place to address this problem. There was an inability to backfill short notice cancellations in theatres due to isolation and swabbing requirements. Further efficiency work was required as part of BAU, also taking into account the impact of Covid-19 and being mindful of healthcare acquired infections.

The Committee **NOTED** and **RECEIVED** the Integrated Performance report for August 2021.

152/21 RECOVERY UPDATE

The Assistant Director of Performance highlighted the following proposed changes to the recovery trajectories:

- P2s and > 104 weeks are the PRIORITY
- 5% P2 patients over 1 month old (over the 4 week standard) by the end of September 2021 – previously zero

- 5% P3 patients over 3 months old (over the 3 month standard) by the end of Q1 2022/23 - previously zero
- 99% of patients waiting for Endoscopy to be within 6 weeks of referral by the end of November 2021 – previously end of June 2021
- 99% of patients waiting for Neurophysiology and Cardiology to be within 6 weeks of referral by the end of November 2021 – previously end of June 2021
- After November running Diagnostics surveillance so need to retain insourcing
- 5% patients waiting over 22 weeks as an ASI by the end of November 2021 (exception in ENT) - previously zero
- 104week waits will be cleared outside of P5&6

It was noted that P3 patient numbers were likely to be lower than pre-Covid when cross-site there were 130 elective theatre sessions per week. In the current week there were 80-82 sessions, due to high vacancy levels, high sickness, less bank and agency shifts taken up, redeployed staff, a smaller footprint and flow issues, hence insufficient capacity to complete P2s over 4 weeks and 104-week waiters and P3s. Should there be a further impact from Covid-19 during the winter months there would only be sufficient staff to support surges, with staff from theatres and endoscopy being redeployed. In Neurology there had been an increased demand for diagnostic tests linked to the paper referral process, which carried a level of error, with administrative reviews recognising further patients. There were plans to move to e-referrals in October. The backlog in Cardiology related to Echocardiograms, which was being addressed, although there were workforce challenges as the internal training programme for technicians would not see benefits until next year. There was a regional requirement to address follow-up P2 outpatients and eliminate the number of 104-week waiters by the end of March 2022. The Trust Chair said that at a NE&Y elective recovery event it was stated that Chairs and CEOs would be held to account for performance. There was also a possibility that the data may be released into the public domain so that comparisons across the ICS about recovery could be made. It was paramount that our data quality reflected our position.

The Committee **APPROVED** the revised recovery trajectories to recognise and agree to prioritise P2s and 104-week waiters (majority P4s), as per NHS England requirements, dependent on Covid impact and winter pressures.

Financial Recovery Planning – it was noted that the overall commitment to recovery in H2 was £8m. The commitment to the IS to support elective recovery was £4.8m through agreed contracts. However, there was an associated administrative burden and a need for additional resource of £100k. The Trust would therefore be continuing at risk from July at which point the ERF threshold had changed, although the risk had changed again with the new H2 ERF as funding for the IS was an opportunity. There would need to be achievement of an aggregate ICS position to determine if CHFT would attract income to cover costs. This would be incorporated in the H2 financial plan being submitted to the November Board of Directors. It was noted that the contracts with the IS were funded per patient but these costs did not include assumptions around enhanced pay on the internal activity.

The Committee **NOTED** the committed expenditure for H2.

153/21 DRAFT MINUTES FROM SUB-COMMITTEES

The following minutes and summaries thereof were received by the Committee:

- Urgent & Emergency Care Board – 13 July 2021
- CHFT/THIS Contract Review Meeting – 24 August 2021
- THIS Executive Board – 25 August 2021
- Capital Management Group – 13 September 2021
- HPS Board – 14 September 2021

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

154/21 WORKPLAN - 2021/22

The Work Plan was **NOTED** by the Committee.

155/21 MATTERS TO CASCADE TO BOARD

The Chair would prepare his highlight report for the Board of Directors and circulate to the Committee.

156/21 ANY OTHER BUSINESS

There was no further business.

DATE AND TIME OF NEXT MEETING:

Monday 1 November, 11:00 – 13:00, Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Monday 1 November 2021, 11.00am – 13.00pm Via Microsoft Teams

PRESENT

Peter Wilkinson	Non-Executive Director (Chair)
Kirsty Archer	Deputy Director of Finance
Gary Boothby	Director of Finance
Owen Williams	Chief Executive
Philip Lewer	Trust Chair

IN ATTENDANCE

Suzanne Dunkley	Director of Workforce & Organisational Development
Peter Keogh	Assistant Director of Performance
Andrea McCourt	Company Secretary
Jim Rea	Managing Director – Digital Health
Philippa Russell	Assistant Director of Finance
Thomas Strickland	Director of Operations – Surgery
Simon Sturdee	Consultant – Trauma and Orthopaedic
Stephen Shepley	Director of Operations - Administration
Jane Mackenzie	General Manager – Administration
Nicholas Buckley	Appointment Services Manager
Mark Whitwam	Assistant Appointment Services Manager
Rochelle Scargill	PA to Director of Finance (Minutes)
Robert Markless	Public Elected Governor
Brian Moore	Public Elected Governor

ITEM

157/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting. Welcome to new Governors Robert Markless and Brian Moore.

158/21 **APOLOGIES FOR ABSENCE**

Apologies were received from Richard Hopkin.

159/21 **DECLARATIONS OF INTEREST**

There were no declarations of interest to note.

160/21 **MATTERS ARISING**

161/21 **Terms of reference and quoracy** - The terms of reference for this meeting were reviewed. New section 5.3 has been added and refers to the Executive Director or Non-Executive Director nominating a deputy if they cannot attend the meeting. The deputies will count towards quoracy.

The Committee **APPROVED** the terms of reference.

162/21 **ACTION LOG**

The Action Log was reviewed as follows:

Outpatient Improvement – The Assistant Appointment Services Manager provided an update following the project work carried out by Meridian. The centre is now more statistically driven. A target has been set for 2000 appointments a week and the team are consistently passing that. 26 specialities are covered. The project has allowed for better planning of staff resource with more being rostered at peak times.

A Band 5 Validation post has been recruited to review processes and procedures across different systems. The Room Booking Co-ordinator has been in post for last three months. This role is to ensure better utilisation and visibility of rooms for managers.

Meridian did not review the templates. The Project team reviewed and have reduced the number of staff who can sign off templates. Training is to be provided to users. No increase in staffing levels in the centre, but the way of booking has changed. Moved to priority booking with the assistance of clinicians involved.

131/21 **Neck of Femur Performance (NoF)** – Update on Divisional Improvement Initiative. This was a follow up to the paper submitted at the September 2021 meeting. The aim of the service improvement was to consistently achieve surgery within 36 hours for 70% or more of qualifying patients. The quicker patients get into theatre the better the outcome. Prior to January 2020 the rates were better than the national average. During Covid nationally mortality increased as a number of NoF patients were Covid positive. The Trust is currently still above the national average. Lack of theatre capacity was the main contributory factor in around 50% of the cases that did not meet the target.

Some other Trusts have an Orthogeriatric led unit. This is not something that CHFT currently has. The Trust has just one Geriatrician which can make it difficult to meet the 36 hour target. There would be a benefit to bringing the Trust in line with other local Trusts. Under Payment by Results arrangements this would have allowed the Trust to meet the best practice tariff. The team plan to “go see” other Trusts to review their models as each one does it differently.

FINANCE & PERFORMANCE

163/21 **MONTH 6, FINANCE REPORT (INCLUDING HIGH LEVEL RISKS & EFFICIENCY PERFORMANCE)**

The Deputy Director of Finance highlighted the key points reported at Month 6. The first half of the year ended on a positive with a break-even position. However, in month there was an adverse variance of £1.6m. This is driven by an increase in expenditure seen notably in the last two months. Two key factors have impacted the figures. The enhanced pay rate for bank staff is driving a pressure of circa £800k per month. In addition, against the CNST contribution an expected £1m rebate for the Maternity Incentive Scheme will not be received

as planned as not all targets have been met in full. The forecast position is covered under the H2 plan agenda item.

It was noted that there has been an Improvement in aged debt due to payment from Health Education England.

The Committee **RECEIVED** and **NOTED** the Month 5 finance report.

164/21 **H2 FINANCIAL PLAN**

Plan to be submitted to cover the period October to March, Half 2 (H2) of the financial year. Planning guidance was received on 30 September 2021. This guidance confirmed a financial settlement for NHS £5.4bn overall. This includes £1.5bn for recovery of elective work of which £0.5bn is capital funding, referred to as the Targeted Investment Fund (TIF). The TIF value is £32m for the ICS, the share for CHFT being £6.4m. The capital is intended to enhance the ability to deliver elective recovery.

The ICS revenue planning submission deadline to NHSI/E is 12 November 2021. Information has already had to be submitted on CHFT activity and capital (TIF) bids.

Key priorities outlined in the guidance were described as:

- Eliminate 104 week wait times by March 2022 with exception for P5's and P6's
- Hold or where possible reduce the 52 week waits.
- Stabilise waiting lists
- Cancer return more than 62 day waits to the level seen in February 2020.

The current activity plan will achieve these expectations.

In H1 to access the Elective Recovery Fund (ERF) required delivery of more than 95% of the 2019/20 volumes of activity. ERF will now be based on completed referral to treatment pathways exceeding 89% of 2019/20 levels.
Both CHFT and BTHFT have gaps in the 2019/20 baseline data due to the installation of EPR. As a result, performance will be measured on an activity basis as per H1. Clarification has been sought as the Trust were initially told would be on an 89% volume basis. The suggested figure from NHSI/E now is 95%. The current plan projects monthly activity at 89% - 93%. As such, based on the higher 95% threshold to secure funding would not be reached. If the lower 89% were to be confirmed circa £1m funding opportunity may exist. CCGs can access ERF for independent sector contracts where expenditure exceeds 2019/20 levels but this route is not open to Trusts. No Elective Recovery Funding has been included in the financial plan due to the uncertainty described coupled with the fact that the whole ICS must meet targets in aggregate to secure funding.

With regard to the H2 funding allocation the following was noted:

- Pay award including backpay funded through allocations.
- Funding allocations reduced due to inbuilt efficiency requirement.

- Additional allocation of capacity funding to support winter / emergency activity pressures.

Against this the H1 exit run rate is driving a higher cost in the second half of the year. There is a total recovery commitment of £7m and enhanced bank rates are forecast to remain in place. This scheme is to be reviewed through Executive board to find a more targeted approach to having the correct staffing levels.

Having planned for an efficiency target of £6.7m to be delivered, a residual deficit forecast for H2 of £3.8m remains. Mitigation against this is a potential £2.1m allocation adjustment as a result of joint working with system partners, leaving a £1.7m residual planning gap.

The committee discussed the position and it was agreed to recommend to the Trust Board a plan to breakeven (excluding a one off technical accounting adjustment of £5m), noting the challenging scale of the efficiency requirement.

The committee also noted the £6.5m bid for capital funding from the ICS allocation, to be confirmed. Capital expenditure to be committed before the end of the financial year.

The Committee **APPROVED** and **RECOMMENDED** to Board to approve a breakeven plan.

165/21 **EFFECTIVE AND EFFICIENT USE OF RESOURCES AT CHFT**

A new group has been created called the Effective Resources Group (ERG) The weekly meeting will be chaired by CEO and the aim is to plan and deliver effective resources to support delivery of the Trust's financial plans. Terms of reference for the new group brought to the committee for approval.

The Committee **APPROVED** the terms of reference.

166/21 **INTEGRATED PERFORMANCE REVIEW – SEPTEMBER 2021**

The Assistant Director of Performance reported that the Trust's performance for September 2021 was down to 66.4%, which is the lowest it has been this financial year. He noted difficulty in achieving complaints responses. SHMI has gone over 100 and in September all four stroke indicators were missed. Despite this the Trust still has 4 green domains.

It was noted that the operational pressures are now being reflected in the KPIs. Tougher friends and family targets were brought in in September. This will have an impact on results as currently slightly below the new targets where previously they were above the old targets. This will probably be reflected in the October report.

Comparatively still in a good position against our West Yorkshire peers.

<u>Responsive</u> – This is the most volatile area due to operational challenges. Complaints and PALS contacts are up. There is a planned risk summit for system leaders to discuss these around quality and safety impacts.

Workforce – Now amber due to short term sickness reaching amber. Highest levels since November 2020. There has been an improvement in return to work interviews. A revised "worry ward" dashboard has been approved and is monitored weekly as part of the senior staffing group.

The Committee **NOTED** and **RECEIVED** the Integrated Performance report for September 2021.

167/21 RECOVERY UPDATE

The Assistant Director or Performance covered the priorities and operational guidance for H2. Six areas set out in March remain the priority.
Changes to recovery remain the same as those shown at the last meeting.
Some targets were being achieved ahead of what has been asked for nationally. There are a number of new clock starts based on the average of previous months.

Planned Endoscopies that have gone past their TCI dates have been included in the RTT pathways. As a result, the RTT will increase over the next few months but will reduce subsequently. The Trust is tracking 52 and 104 week waits weekly to achieve March targets.
Patients are now waiting on average over 20 weeks. Whereas pre-pandemic this was around 9 weeks.

168/21 COLLEAGUE AVAILABILITY DEEP DIVE

The Director of Workforce & Organisational Development provided an update on the current staffing position.

- Availability includes annual leave (+other) as well as absence or Covid absence. Some colleagues are taking study leave at the moment.
- Current absence stands at 5.61% and our target is 4%. The 5.61% includes Covid absence and isolation.
- Unavailability – including all reasons for absence -stands at 21.8%
- Covid absence and isolation accounts for 23.6% of unavailability. Isolation is included whether colleagues are working or not.
- In September days lost to stress anxiety and depression have fallen for the first time in 21/22
- Twenty-seven clinical areas have absence higher than 10%.
- CHFT reports absence as per the NHSE/I guidelines. This may not be directly comparable with other WYAAT organisations.
- Annual leave roster management could be improved. Particularly around school holidays.
- Only 43.1% of annual leave has been taken. Should be 75% by the end of December.
- Around 44% of staff in the NHS have had some time off over the last 18 months due to mental health issues.
- Non Covid absence has increased. This is a pattern seen across other Trusts. Work is needed around long term absence.
- Wellbeing calls have resulted in support being offered to colleagues. A new Clinical Guardian has been appointed.
- Isolations include household isolation. Currently looking at ways to mitigate this.

- Colleagues carried annual leave over from last year. Including high numbers from colleagues who would not necessarily have been expected to carry it over. This will cause pressures later when staff want to take their leave.
- Looking to increase focus on wellbeing and making sure that colleagues are receiving the basics, encourage them to take annual leave and promote the wellbeing hour.

Finally, it was noted that there are five winter must do's that have been agreed through Executive Board – patient flow, IPC, one culture of care, safe staffing and delivering value for money.

ACTION: Slides to be sent to committee members.

169/21 **DRAFT MINUTES FROM SUB-COMMITTEES**

The following minutes and summaries thereof were received by the Committee:

- Capital Management Group – 14 October 2021
- THIS Executive Board – 29 September 2021
- CHFT/CHS Joint Liaison Committee – 06 October 2021

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

170/21 **WORKPLAN - 2021/22**

Workplan for 2021/22 was noted with no amendments

171/21 **MATTERS TO CASCADE TO BOARD**

Terms of reference for this committee.
H2 Financial plan approval.

172/21 **REVIEW OF MEETING**

No specific review carried out

173/21 **ANY OTHER BUSINESS**

There was no further business.

DATE AND TIME OF NEXT MEETING:

Monday 29 November, 11:00 – 13:00, Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Monday 29 November 2021, 11.00am – 1.00pm Via Microsoft Teams

PRESENT

Richard Hopkin	Non-Executive Director (Chair)
Peter Wilkinson	Non-Executive Director
Gary Boothby	Executive Director of Finance
Jo Fawcus	Chief Operating Officer
Anna Basford	Director for Transformation and Partnerships

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Philip Lewer	Trust Chair
Peter Keogh	Assistant Director of Performance
Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Robert Markless	Public Elected Governor
Isaac Dziya	Public Elected Governor – (IPR item onwards.)

ITEM

174/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting. Welcome to the new Chief Operating Officer – Jo Fawcus.

175/21 **APOLOGIES FOR ABSENCE**

Apologies were received from Brian Moore, Stuart Baron, and Ellen Armistead.

176/21 **DECLARATIONS OF INTEREST**

There were no declarations of interest to note.

177/21 **MATTERS ARISING**

178/21 **ACTION LOG**

The Action Log was reviewed as follows:

179/21 **Colleague Deep Dive –** The slides presented at the last meeting are included in the meeting pack. A decision needs to be made as to how often the deep dive will be brought to this meeting as workforce detail is covered within the IPR. To be agreed outside of meeting and added to workplan. ACTION: RH / SD / RLS

180/21

125/1 IPR – July 2022– This action can be closed. The plan was to review the outcome-based indicators added into the IPR. Add a new action to do a post mortem of changes to IPR over the last few months at the next meeting or one after.

A review of the performance accountability framework is taking place as part of WEB. The review is to be brought to this meeting as well as WEB.

ACTION: PK/JF Review of performance accountability framework and revised IPR to come back to this meeting.

138/20 Stroke Deep Dive: Date to be agreed when 2022 dates arranged.

090/21 Self-Assessment Action Plan: Currently marked as closed on the action plan but this is an error. RH to complete before end of calendar year and bring to the meeting arranged for the 6th January 2022. ACTION: RH

131/21 Neck of Femur Performance: Update was received at the last meeting and the next one is due at the meeting currently arranged for 31st January – the date of this meeting will change due to a clash with a new meeting arranged by Brendan Brown as incoming CEO.

FINANCE & PERFORMANCE

181/21 MONTH 7, FINANCE REPORT (INCLUDING HIGH LEVEL RISKS & EFFICIENCY PERFORMANCE)

The Deputy Director of Finance highlighted the key points reported at Month 7. The report focussed on Month 7 rather than the full year. Currently reporting £1.24m deficit in month. Whilst the Trust has submitted a balanced plan for the year and has delivered a break-even position in the first half of the year (H1), the financial position remains challenging. H2 includes a significant efficiency requirement of £6.7m with less than five months to deliver the savings. The deficit is worrying and a challenge for the remainder of the year. There is continued pressure around enhanced bank pay which has totalled £700k in month and £2.5m in year since it commenced in late July.

During the month there has been no accounting for Elective Recovery Funding (ERF) income as our elective activity is below the threshold at an ICS level whereas performance is managed and measured.

Cost Improvement – there has been minimal delivery of efficiencies in month, just over £100k reported in month 7 against £6.7m target for the remainder of the financial year.

Capital and Cash – Capital continues to be beneath original plan as previously described due to a couple of externally funded areas where we have re-profiled expenditure which will fall into future periods. Cash position is relatively healthy as it is being supported by the covid funding regime that we are currently in.
A few anomalies in aged debt had been resolved by the end of Month 7 and for the first time the aged debt is below £3m.

Pressures in revenue position and small CIP delivered in month. This has been reflected in the high level risks.

- The risk of not achieving the full year 2021/22 financial plan, the score is to be left at 20 but the narrative has been updated to include facts and figures that are outlined in the H2 financial plan. Score relates to the continued challenging efficiency requirement for H2 of £6.7m.
- Capital and Cash risks scores also remain the same.

The Committee **RECEIVED** and **NOTED** the Month 7 finance report and **APPROVED** the high level risks.

182/21 **EFFECTIVE AND EFFICIENT USE OF RESOURCES GROUP**

The terms of reference were brought to the last meeting. The group is meeting weekly but only started during November. The meeting is on different days and different times due to fitting around existing diary commitments. Therefore the same people have not attended every meeting.

The challenge for 21/22 is complex and the funding streams are being adjusted continually. GB gave a small presentation:

Plan agreed for remainder of year is to breakeven operationally. The guidance was published late so a number of assumptions were made.

- £2.2m winter monies form CCG's.
- Targeted reduction in pay enhancements and other run rate improvements.
- No further support from CCG's.
- No further ERF (Elective Recovery Fund) benefit

Latest update from the last ERG meeting on Friday 26th November, of the £6.7m only £1m has been transacted which is non recurrent, and work is underway developing another £2.7m. Most of these opportunities are non-recurrent but the challenge is recurrent. The group have reinstated Equality Quality Impact Assessments and Quality Impact Assessments that were previously used. This will ensure that the opportunities do not increase risk of patient harm or quality of care.

The Trust is intending to hold back on recruiting to non-patient facing roles in order to accommodate frontline staff who are unable to have the Covid vaccinations. Mandatory vaccinations will be required from 1st April 2022. This will provide a cost benefit to this financial year.

It is expected that extra resources will be made available nationally and within ICS. The ICS are funding the national living wage in care homes.

There is a possibility of receiving some funding from the ERF due a relaxation of some rules around claiming the funding.

Agreed some support from CCGs and continued discussions with Mid Yorkshire around them paying for CHFT support for non-surgical oncology, also agreed funding for costs CHFT are incurring around vascular work for Bradford. Some of these had already been included as assumptions in the plan for H2.

Message to Trust is to reinforce the £6.7m deficit and to encourage colleagues to look for recurrent savings.

Culturally, identifying savings is very difficult. Cases were agreed at Commercial Investment and Strategy Committee which will add to the challenge for 2022-2023.

In summary a fast-changing year end picture and the objective is to deliver and minimise the impact on 22/23. It is expected that the plan will be delivered albeit

through external support and it was agreed to keep the in-year risk score as 20 due to the non-recurrent nature of in year support and to support the additional focus on finance.

The Committee **RECEIVED** and **NOTED** the report from the Effective and Efficient Use of Resources Group.

183/21 INTEGRATED PERFORMANCE REVIEW – OCTOBER 2021

The Assistant Director of Performance reported the Trust's overall performance score for October 2021 was 64.6%, following on from an adjusted September position of 61%. Friends and family test results are now aligned to the month being reported not the previous month as before. This impacted on the September position. There was also a late 31 day cancer breach which made the Responsive domain red. This has improved in October and Responsive is now Amber. The Emergency Department has been very busy which is reflected in the domains. There has been an increase in the number of complaints and less positive results in the friends and family test. This is not unique to CHFT.

Safe domain remains Green.

Caring domain is amber but now has challenges in complaints, friends and family test and Dementia screening.

Effective domain remains green and although fracture neck of femur is improving, we are seeing some surges in orthopaedic activity which impacts getting the timescales for neck of femur patients.

Responsive domain was covered above and is the most volatile area

Workforce domain remains Amber with short term non-Covid sickness at its highest level over the last 12 months. Return to work interviews are at their lowest level since January. Staffing does impact on all other areas.

Finance domain remains Green.

Challenges in community around providing care beds to reduce delayed transfers of care. Work going on around wellbeing and supporting staff. The Trust is trying to plan for Christmas and New Year looking at leave and what can be done differently. Last week some beds were closed on the acute floors which really helped to improve fill rates. Also using lessons learnt from the previous weekend of bad weather in order to plan for future episodes.

The Committee **NOTED** and **RECEIVED** the Integrated Performance report for October 2021.

184/21 RECOVERY UPDATE

The Assistant Director or Performance presented a recovery update as follows:

P2's and 104 week wating list are the current priority. Plans for H2 are included in the presentation but were not discussed in this meeting. There has been a

directive from the centre requesting that patients who have been waiting over 82 weeks are dated as they are more likely to hit the 104 by the end of March. Across the whole ICS a low number of patients have been dated at this moment in time. CHFT is confident of the numbers submitted for 104 week wait times, and how we are going to achieve it. The request is to date all non-admitted patients by the end of November and then date the admitted.

P2's are going in the right direction with the current figure now at around 50, previous meetings have agreed 5% of our total number is the target. More detail in IPR shows that the number of patients being treated is now higher than numbers that are being added.

P3's -This was going to be a challenge to achieve, and the trajectory has been set to first quarter of 22/23 which would be two years since the pandemic started. The aim is to have reduced the 104 week waiters which will then allow focus to move onto the P3's. There has been an increase but comfortable with the trajectory.

P4's – The numbers are coming down as there are no empty slots. If any slots cannot be filled with 104 week wait, P2's and P3's then the P4 list is being used. Number of Referral to Treatment Open Pathways shows the total number of patients CHFT have waiting. The plans for H2 were to maintain September's position. The figures show it is moving in the right direction.

Appointment Slot Issues (ASI's) over 22 weeks, having trouble to get slots for outpatients, plan is to reduce this number by end of November with a couple of exceptions in specialities. Numbers are heading in the right direction.

Elective update – Endoscopy and diagnostic waits, two bottom charts have an issue with the colours compared to the top chart. This will be rectified to be sent out with the minutes. **ACTION PK** The Trust should be treating 99% of diagnostic patients within 6 weeks. Endoscopy are on track for the end of November. Neurophysiology and ECHO are aiming to be back on track by January 2022.

P5's and P6's not included in targets as not prioritised to be seen due to Covid or have chosen to wait.

104 weeks- There are 40-50 patients waiting for 104 weeks. The plan is to reduce this to as near to zero as possible by the end of March.

52 weeks – in H2 trajectory, maintaining September's figures.

Average wait is now over 20weeks. Pre-pandemic this was around a 10 week wait.

Patient Initiated Follow Up (PIFU) attendances – Target is to move 1.5% of all patients to PIFU pathways by December and target of 2% by March.

Focus from NHSi on recovery plans. NHSi is instructing Trusts to book all patients over 80 weeks into capacity. Can only book six weeks ahead for

theatre capacity. Software can be purchased to overlay the waiting lists to tell us the clinical impact.

The CHFT data has had a lot of work put into the integrity and quality including validation of records This work started before the pandemic so while the numbers might be high, the data is accurate. Realistic targets have been given for recovery.

185/21 **STOP METRICS**

A discussion took place at both the Finance and Performance committee and the Non- Executive group. What are the key metrics that must be focussed on? If a number are in red does the way of working need to be reviewed?

Four key areas have been identified - Staffing, Covid Management, Elective Recovery and Non-Elective Management. Over 100 possible metrics need to be narrowed down. Finance, Quality and complaints go across all of these areas. The STOP metrics were identified by the NEDS in a Board workshop session. This is a high level, one page of metrics with a traffic light system to highlight areas of concern. Is this a format to use? Not to diminish from IPR.

Aim was to aid the non-executives of their view of Trust position as they are not involved in other conversations within the Trust. Non-Execs to discuss separately to see if this is what they were looking for. Further discussion at the Board workshop on 2nd December.

ACTION: RH/PK to agree ongoing requirement re STOP metrics following Board discussions.

186/21 **DRAFT MINUTES FROM SUB-COMMITTEES**

The following minutes and summaries thereof were received by the Committee:

- Capital Management Group – 14 November 2021
- THIS Executive Board – 27 October 2021
- HPS Board – 22 November 2021

The Cash Management meeting was cancelled for capacity reasons. Next meeting due in January.
No minutes have been received from the Urgent and Emergency Care Board.

The Committee **RECEIVED** and **NOTED** the key points from the Sub-Committees.

187/21 **WORKPLAN - 2021/22**

Workplan for 2021/22 was noted with no amendments
The BAF risks have been deferred to the January meeting.
THIS commercial strategy paper due in January but was presented a short time ago. **ACTION**: RLS to speak to GB and JR. May need to be pushed back for a couple of months.
Need to start thinking about the workplan for 2022 - 2023

188/21 **MATTERS TO CASCADE TO BOARD**
Key points to be covered to Chair's Highlights Report to Board.

189/21 **REVIEW OF MEETING**
No specific review carried out

190/21 **ANY OTHER BUSINESS**
Isaac, Robert or Brian to contact Richard if they have any queries or questions.

Future meetings, the first meeting in January has been moved from the 10th January to the 6th. The new Chief Executive has put a new meeting in on Monday mornings which will clash with the planned dates for this meeting. Keep the existing dates for now as the Chief Executive is a member of this committee and discuss once he is in post.

DATE AND TIME OF NEXT MEETING:
Thursday 06 January, 10:00 – 12:00, Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 11 October 2021

STANDING ITEMS

176/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Dr David Birkenhead **(DB)**	Medical Director
Lisa Cook **(LC)**	Head of Risk and Compliance
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Enzani Nyatoro **(EN)**	Interim Assistant Director for Patient Safety
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / Greater Huddersfield / North Kirklees CCGs
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Ruth Dobbins **(RD)**	Student Midwife **(observing)**
Alexandra Keaskin **(AK)**	Lead Nurse – Quality **(observing)**
Gemma Pickup **(GP)**	Quality & Service Improvement Lead **(item 181/21)**
Neil Staniforth **(NS)**	Associate Director for Digital Health **(item 180/21)**

177/21 APOLOGIES

Ellen Armistead **(EA)**	Executive Director of Nursing

178/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

179/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 13 September 2021 were approved as a correct record. The action log can be found at the end of these minutes.

AD HOC REPORTS

180/21 FAILED PATIENT LETTERS

Neil Staniforth was in attendance to present appendix C, informing the Committee of an issue relating to patient letters, and providing assurance that it has been fully investigated and resolved.

In August 2021, an issue was identified where 12,000 patient letters had failed to be sent, between August 2020 and August 2021. The handling of the issue was described in the paper, and in less than 1% of patients reviewed, there were found to be errors where follow-up diagnostic procedures were not requested. NS assured the Committee that no patients came to harm due to the delays in requesting diagnostic procedures and agreed to return this data to the Committee.

OUTCOME: NS was thanked, and the Quality Committee noted the report.

181/21 REVIEW OF ORGANISATIONAL PERFORMANCE AGAINST 36 HOUR ADMISSION TO SURGERY TARGET WITHIN BEST PRACTICE TARIFF

Gemma Pickup was in attendance to present appendix D, providing assurance that the surgical division are reviewing the current performance, developing a divisional action plan to improve performance and reducing the Trust's hip fracture related mortality rate.

During 2020, the Trust's performance against the 36-hour admission to surgery target reduced, and the overall annual performance was 64.7%. This reduction in performance continued into 2021 with the year-to-date figure at 57.7%. Whilst the average length of time to surgery is still below 36 hours, this has significantly increased since the beginning of January 2020. The National Hip Fracture Database reports that the Trust's mortality rate associated with fragility hip fracture patients rose above the national average in January 2020 and has remained above throughout 2020. In response, the Division commissioned a review of the hip fracture, which is currently ongoing and due to be concluded by September 2021.

The aims, reality, response and further actions for the service were described in the report.

In relation to the completion of the process map to improve performance and identify inefficiencies, GP confirmed one outstanding section which is incomplete due to clinical pressures.

In terms of the full review of mortality data being undertaken, it was asked whether this will be done from a health inequality perspective. GP stated that this would automatically be carried out, however, would confirm to ensure that this is being captured.

With regard to falls reductions, it was asked whether any data was available on the number of patients who fall or fracture as an inpatient. GP reported that a paper is due to be submitted to the Finance and Performance Committee in November 2021, which will include the noticeable aspect of inpatient falls.

The Chair asked if there were any concerns with the National Improvement Initiative business case not being approved. GP stated that there were no indications of such.

An update on the action plan was requested for six months' time.

OUTCOME: GP was thanked, and the Quality Committee noted the report.

SAFE

182/21 MEDICAL GAS AND NON-INVASIVE VENTILATION (NIV) GROUP REPORT

Elisabeth Street presented a progress report from the Medical Gas and Non-invasive Ventilation Group at appendix E, briefly highlighting areas of risks and concerns and actions taken.

There had been a long-standing risk around occupational exposure levels for staff working in areas where nitrous oxide and Entonox gas is administered. Testing was carried out on both sites, and reports and findings received. Most areas showed exposure within safe levels, however, one area's level was above the recommended level. A further check was carried out and the area retested. The results are being awaited. It was noted that this test will be carried out on an annual basis.

Another outstanding risk was in regard to training used for the clinical side of administering oxygen and also for the use of the cylinders. A subgroup of the medical gases group who specifically review oxygen training produced a training programme called 'SWAY', which is due to be rolled out.

A Healthcare Safety Investigation Branch (HSIB) report published on the safe use of oxygen in organisations during the period of COVID was reviewed, and work has been carried out between medical engineering, estates and clinical teams on the recommendations to ensure capacity on both sites for 50 designated nursing officers and medical officers who have now been trained to be medical oxygen and medical gas experts.

In regard to a ventilation audit, existing wards at HRI have not had their medical gas supply refurbished for over 25 years which is a risk in terms of ventilation and oxygen. Ward 11 and 15 have escalated concerns and added this to their risk registers. If there was funding for oxygen infrastructure, a ring main system could be designed to provide greater flow and resilience, with no single point of failure.

The Chair commented on the report and the progress with the medical gases agenda.

OUTCOME: ES was thanked, and the Quality Committee noted the report.

183/21 Q2 INFECTION PREVENTION AND CONTROL BOARD REPORT

Dr David Birkenhead presented appendix F, providing an update on performance relating to Infection Prevention and Control from 1 July to 30 September 2021.

There has been an improved position over the last year, however, there are some challenges in relation to objectives set, in particular Clostridium difficile, with an objective of 22, which is substantially less than it has been previously. Nonetheless, there has been improved performance on the number of cases compared to this time last year.

The challenge with Aseptic Non-Touch Technique competency assessments during the junior doctor rotations in August continues. There will be a catch-up period for the completion of those, however, training across the organisation remains stable.

COVID continues to present a significant challenge within CHFT, with almost 100 patients in hospital. There have been small numbers of hospital onset COVID cases amongst patients who have been vaccinated, and both patients and staff coming into hospital asymptomatic and subsequently developing COVID at a later date.

Infection Prevention and Control precautions around COVID remain unchanged, and patients and staff are still required to wear masks and to practice social distancing whilst at work, as there is a substantial risk of transmission in community settings.

It was noted that increasing evidence shows that after six months, the efficacy of the COVID vaccine starts to reduce, therefore, CHFT are currently engaged in a booster vaccine programme, which has now entered its third week. This is a joint programme against COVID-19 and influenza, with two separate vaccines being offered. This is progressing well at this point in time.

OUTCOME: DB was thanked, and the Quality Committee noted the report.

184/21 Q1 TRUST PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT

Lindsay Rudge presented appendix G summarising work undertaken in the Trust PSQB during April to June 2021.

The meeting was jointly chaired between Lindsay Rudge and Dr Cornelle Parker through the quarter one period, with sub-group reports received from the Medical Devices and Procurement Group, Medication Safety and Compliance Group, Radiation Protection Board and the Thrombosis Committee.

All groups have been active in work undertaken. The Medical Devices and Procurement Group have worked on scan for safety which is important in terms of tracking and making

equipment available; improving the procurement process to ensure that equipment is not being procured outside of procedure, and also expanded their equipment pool to provide a service to frontline areas ensuring equipment is available at the point of need and can be tracked. The Medication Safety and Compliance Group is an active group working on digital aspects to support safety in medication with temperature monitoring and electronic controlled drug cupboards. The Radiation Protection Board will be reviewing the non-ionising radiation protection governance arrangements, and an update will be received into the PSQB around the arrangements put in place. The Thrombosis Committee have reviewed venous thromboembolism data and will be updating on their getting it right first time (GIRFT) action plan through the PSQB.

Other key points to note are actions requested via the divisional PSQBs regarding the closure of orange and red incidents and related outstanding actions; further requests for work on improving how lessons learned are described; an improved patient safety alert position, and the escalation to the Quality Committee of an incident where a syringe driver was reported on Datix, put back into use, and reported again. Recommendations have also been made on how the Trust PSQB can work more efficiently at capturing learning going forward.

In relation to the syringe driver incident, it was asked whether any communication has been disseminated. LR reported that it is an agenda item at the daily tactical meeting.

OUTCOME: LR was thanked, and the Quality Committee noted the report.

185/21 HIGH LEVEL RISK REGISTER

Lisa Cook presented appendix H, updating on the high-level risk register.

There were 26 risks on the high-level risk register with little movement in the existing risks. One new risk was added (6453), one risk removed (7769) and one risk reduced (7328) since the last update, all of which were detailed in the report.

Discussion took place on the deep dive into the nurse staffing risk at the Workforce Committee, and a suggested consideration to escalating the risk further. LR stated that a review of the data has been commissioned in terms of nurse staffing, patient acuity and how it is described, however, it has not yet been concluded.

LC commented on discussions with divisions about an overall risk of staffing, and how it impacts within different areas. This will be reviewed by the Risk team as part of the review of the risk registers, and support for divisions.

OUTCOME: LC was thanked, and the Quality Committee noted the report.

WELL-LED

186/21 BOARD ASSURANCE FRAMEWORK RISK 4/19 – PUBLIC AND PATIENT INVOLVEMENT

Lindsay Rudge presented appendix I, providing assurance on the deep dive of the board assurance framework risk 4/19 on public and patient involvement.

The controls of the risk were reviewed and updated, and a health inequalities group established, with a number of positives assurances, as detailed in the paper, which have progressed despite the impact of the pandemic.

It was noted that the risk score has not been reduced.

In terms of current capacity on patient and public involvement, it was asked whether work delivered so far could be sustained and progressed. LR stated that the capacity for the patient experience manager role has been increased from part to full-time to include more around

public and patient involvement, and progress work in partnership with other services within the Trust.

The Committee were asked to note the updated risk, to ensure that the Patient Experience Group remains a priority across the Trust and to ensure that patient stories focus on experiences of people from protected characteristic groups.

OUTCOME: LR was thanked, and the Quality Committee noted the report.

RESPONSIVE

187/21 QUALITY REPORT

Enzani Nyatoro presented appendix J, providing the key points from the detailed report on Care Quality Commission, patient safety alerts, dementia screening, experience, participation and equalities, legal services, incidents, medicine safety, maternity services, and bi-monthly updates from the quality account priorities and the focused quality priorities.

OUTCOME: The Quality Committee noted the report.

188/21 INTEGRATED BOARD REPORT

Lindsay Rudge reported on appendix K, and the Trust performance for August 2021 of 70.4%, which is a deterioration on the July position.

The caring and responsive domains remain a challenge, as well as increased non-COVID long-term sickness in the workforce domain. The threats within the strengths, weaknesses, opportunities and threats (SWOT) analysis were highlighted, especially the very challenging emergency department position, the ongoing position with the backlog and theatre capacity, and support in community in terms of the vaccination program for children and young people.

The report is reflective of the current operational pressures across the organisation. There was a large increase in complaints and an indicator where performance is slightly deteriorated, with work ongoing to review how this is managed with divisions.

JE reported on return-to-work interviews and the catch-up described at the last meeting which did not take place, therefore, there has been a deterioration. Attendance management activities have returned into the operational HR teams, including return to work interviews, to assist frontline managers to focus on other priorities. It is hoped that the 80% position of completed return to work interviews is sustained.

The Chair asked whether the ring-fenced stroke bed in the emergency department is always accessible for stroke patients. LR stated that a pre-alert is received for stroke patients, and where possible, the bed is made available. There may be challenges at times due to current occupancy and demand through the emergency department, however, it may be worthwhile to know if there have been any incidents where the bed was not available and the impact that may have had.
Action: To ascertain the impact of any incidents relating to the stroke bed in the emergency department not being available.

In relation to safeguarding, the Chair requested a report on medical reconciliation within 24 hours (excluding children), due to performance being in the red for the past 12 months.
Action: A paper regarding performance on medical reconciliation within 24 hours and how to improve the position

OUTCOME: The Quality Committee noted the report.

189/21 QUALITY COMMITTEE ANNUAL REPORT

The annual report will be circulated once completed.

EFFECTIVE

190/21 Q2 LEARNING FROM DEATH REPORT

Dr Cornelle Parker presented appendix M, providing an update on the quarter 2 learning from deaths report.

During quarter 2, there were 344 adult inpatient deaths. For quarter 1, the completion rate using the initial screening tool (ISR) was 32% against a target of 50%. 8% of all in-hospital deaths have been reviewed in quarter 2 thus far, however, there is a time lag within the process from allocation to completion by reviewers. The gap is largely due to specialties with higher volumes of deaths, particularly acute medicine, elderly medicine and respiratory medicine. A recovery plan has been put in place for acute medicine, however, the respiratory and elderly medicine mortality leads are currently struggling with colleague participation due to clinical pressures.

The medical examiner's office is now scrutinising 100% of all inpatient deaths. The primary purpose is to improve the accuracy of the medical certificate of cause of death; however, a secondary benefit is that all deaths are being reviewed very early after a patient death, and currently escalating around 5% of those cases for structured judgment review.

A total of 46 Structured Judgement Reviews were requested in the first quarter of 2021/2022, of which 100% were completed.

OUTCOME: CP was thanked, and the Quality Committee noted the report.

POST MEETING REVIEW

191/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

In terms of escalation to the Board of Directors, the Quality Committee notes receipt of:

- Information received on failed patient letters, and its positive outcome
- Review of organisational performance against 36-hour admission to surgery target within Best Practice Tariff
- Trust Patient Safety and Quality Board report and items escalated
- Board assurance framework risk for Public and patient involvement (4/19)
- Two issues from the IPR regarding ongoing challenges in the ED; ongoing position with backlog and theatre capacity, and the increase in the volume of complaints
- The risk associated with nurse staffing

192/21 REVIEW OF MEETING

There were no updates.

193/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

194/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix N for information.

NEXT MEETING

Monday, 8 November 2021	3:00 – 4:30 pm	Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 11 OCTOBER 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
FUTURE ACTIONS				
11.10.21 (188/21)	**Integrated Performance Report**	**Risk Team**	The Chair asked whether the ring-fenced stroke bed in the emergency department is always accessible for stroke patients. LR stated that a pre-alert is received for stroke patients, and where possible, the bed is made available. There may be challenges at times due to current occupancy and demand through the emergency department, however, it may be worthwhile to know if there have been any incidents where the bed was not available and the impact that may have had. **Action**: To ascertain the impact of any incidents relating to the stroke bed in the emergency department not being available. **Update**: Lisa Cook visited the emergency department at Calderdale on 13th October 2021 and spoke with the matron about the stroke bed in the department, who confirmed there were no issues with the bed not being available and fed back that the pathway works really well. A search of incidents going back to January 2020 was carried out, with no incidents found relating to the stoke bed not being available. There were only 11 incidents in total that were in relation to stroke care.	
11.10.21 (188/21)	**Integrated Performance Report**	~~**Safeguarding Team**~~ **Pharmacy**	In relation to safeguarding, the Chair requested a report on medical reconciliation within 24 hours (excluding children), due to performance being in the red for the past 12 months. **Action**: A paper regarding performance on medical reconciliation within 24 hours and how to improve the position **Update**: It has transpired that medical reconciliation within 24 hours is an issue related to Pharmacy, not safeguarding. An update will be provided by Elisabeth Street at the next meeting in December 2021	

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 8 November 2021

STANDING ITEMS

195/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Lisa Cook **(LC)**	Head of Risk and Compliance
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Enzani Nyatoro **(EN)**	Interim Assistant Director for Patient Safety
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / Greater Huddersfield / North Kirklees CCGs
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Laura Douglas **(LD)**	Matron – FSS Division **(200/21)**
Dr Tim Jackson **(TJ)**	Lead Medical Examiner **(206/21)**
Bronagh McCrudden **(BMcC)**	Student Midwife **(observing)**
Lisa Williams **(LW)**	Assistant Director of Transformation **(item 199/21)**

196/21 APOLOGIES

Gina Choy	Public Elected Governor
Jo Kitchen	Staff Elected Governor
Philip Lewer	Chairman
Karen Spencer	Associate Director of Nursing – FSS Division

197/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

198/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 11 October 2021 were approved as a correct record. The action log can be found at the end of these minutes.

Matters arising

A paper was presented in October 2021, informing the Committee of an issue relating to patient letters. The report provided assurance that the issue was fully investigated and resolved, however, a further request was made to provide an update on the less than 1% of patients who were found to not have had their follow-up diagnostic procedure requested. The outcome of the patients was provided within the follow-up report, which clearly outlines that no patients experienced a delay as a result.

AD HOC REPORTS

199/21 BUSINESS BETTER THAN USUAL (BBTU) QUARTER 2 UPDATE

Lisa Williams was in attendance to present a progress update on business better than usual at appendix C.

This programme was developed following the first wave of the pandemic, where significant engagement was undertaken with internal colleagues, system partners, patients and the general public. Following engagement, 12 themes were supported by the Board of Directors to be taken forward, and of those 12 themes for this reporting period, none were rated red, five were amber, six were green, and one has been fully embedded into practice.

Of the five amber themes:

- Community integration and partnerships - further work is required. A gap analysis was undertaken to review any gaps between CHFT, Locala and Primary Care Network (PCN) provision across both Calderdale and Huddersfield, and action plans are being developed to inform commissioning conversations going forward.
- Working from home - engagement is ongoing with colleagues to understand their experiences of working from home over the last 12 to 18 months. This will inform the approach going forward, along with the impact of any climate impact, economic impact for our local communities and estate utilisation.
- Theatres and new ways of working - further work is required to understand what new models of care will look like, and this remains ongoing.
- Direct assessment pathways - some tools have been piloted in the emergency department (ED) and discussions have progressed onto what the impact of those will be on the ED, same day emergency care (SDEC), reconfiguration plans and what the estate will look like in the future.
- Pathology – due to internal and external capacity problems within primary care, meetings and work together get results (WTGR) sessions have taken place with primary care partners, with clear actions on how to develop new models to try to address capacity issues across the system.

In terms of next steps, the benefits emerging from each of the 12 themes will be clearly identified and articulated, and any financial benefits will then be taken through the new weekly effective resources group which was approved by the Board of Directors last week.

The Chair asked which workstream has proven to be the most challenging, to which LW responded that the theatre workstream, given capacity and workforce constraints and what the model will look like going forward due to several independent sector contracts, is proving to be quite challenging at the moment; as well as the pathology workstream given the capacity issues and restrictions

OUTCOME: LW was thanked for the update, and the Quality Committee noted the report.

SAFE

200/21 MATERNITY SERVICES REPORT

Laura Douglas was in attendance to provide an update from maternity services at appendix D, highlighting:

- Ockenden – CHFT are still awaiting a regional visit from the regional chief midwife. As part of the phase 2 project, the service submitted evidence showing compliance in relation to the Ockenden recommendations, and feedback was received on 26 October 2021, with further work to be done in regard to evidence provided.

- Better births – continuity of carer (COC) – the building blocks to achieving the continuity of carer model were outlined in the report, which will continue to be shared with the Board and the Local Maternity Service (LMS)
- NHS Resolution Maternity incentive scheme - task and finish groups are ongoing to ensure compliancy with all elements of the 10 safety actions required.
- Maternity staffing - despite challenges faced with staffing, a high rate of 1-1 care in labour is being maintained, which is all credit to colleagues working differently. In October, 15 newly qualified midwives, who are currently undertaking induction, were welcomed into the service.

KH added that staffing levels are consistently good and reminded the Committee of the extra funding for the extra midwives, however, trying to secure midwives that are not readily available will difficult.

The Chair asked if there were any discussions taking place across the LMS in relation to staffing, and what other options there may be. EA stated that there is a recognition that all Trusts are in the same place, and the Chief Nurse network will be having a focus on midwifery during its next meeting. Whilst the Trust is awaiting external validation and the regional midwifery visit, a process of internal reviews will be undertaken to check key lines of inquiry, as well as listening events being carried out with colleagues to ensure internal scrutiny is in place.

OUTCOME: LD was thanked for the report, which the Quality Committee noted.

201/21 PATIENT SAFETY SPECIALIST

Dr Cornelle Parker provided a brief presentation on the patient safety specialist role, which is an NHS England/NHS Improvement mandated role for a dedicated whole time equivalent patient safety specialist, who will be fully trained in the national patient safety syllabus. There are five domains within the syllabus: a systems approach, learning from incidents, human factors, creating safe systems and being sure about safety.

The patient safety specialist role will be the lead for patient safety, working full time at band 8, with the ability to escalate immediate risks or concerns to the executive team. The role will provide leadership, visibility, and work with a number of people within and outside of the organisation to further the patient safety agenda. The role will ensure that the above domains are observed and underpinned by a range of principles. They will support patient safety partners, but also help develop a network across the country, which is evolving in relation to patient safety specialists.

The history of the role, progress so far, the nine key work programmes and proposal were provided. In terms of being able to resource the role as described, Lindsay Rudge provided an update as part of the re-aligning of the structure. There will be one post for the Assistant Director for Quality and Safety, and also a Head of Quality and Safety. This full-time role will support the Assistant Director role, alongside the medical lead and links with other colleagues.

The Quality Committee were asked to support the role, which has a cost implication.

OUTCOME: CP and LR were thanked, and all Quality Committee members were supportive of the development of the role going forward.

CARING

202/21 PATIENT EXPERIENCE AND CARING GROUP

Lindsay Rudge presented appendix E, which detailed progress of the Transforming Patient and Carer Experience Programme, and assurance that the Trust is supporting the delivery of the strategic goal of 'Transforming and Improving Patient Care'.

LR reported on an adjustment to the staffing challenges and resources around patient experience noted in the report. LR stated that this has been now been mitigated with support, which has now increased the role to one whole-time equivalent, which will support the quality improvement programme around patient experience.

In relation to making complaints count, focus has been made in terms of meeting the agreed date with complainants, ensuring the quality of responses is right the first time, and on learning. There is a wide range of activities, however, focus is being made on the three areas mentioned, until the end of the financial year.

LR drew the Committee's attention to the impact stories included in the report. The first was around volunteering, which includes experiences of people coming into our services, as well as colleagues that are part of the service. It was noted that the volunteering service will discontinue at the end of November 2021 due to funding. Work is ongoing with Workforce and Organisational Development colleagues around the previous volunteering offer prior to COVID. It was noted that the Quality Committee will be updated in due course. The second impact story related to a young person and their family's feedback, and the third impact story was around the work that colleagues in the surgical assessment unit undertook to ensure that people who were accessing that service had the right information.

The Chair commented that despite the many challenges, there has been action from every area of the workstream which is really positive. LR formally acknowledged thanks to Alison Lodge, who will be retiring from the role of Quality Improvement Manager this month, who has always championed patient experience and been an absolute resource who has pushed this programme on. Alison's work in her role and work done for the organisation was recognised.

CP echoed LR's thanks to Alison, who has been fairly instrumental in the fantastic work which has been done and would not want to lose sight of this work going forward, particularly at the moment, when the quality directorate is under a fair amount of pressure due to staffing and capacity issues. It is important that this agenda is delivered against going forward.

OUTCOME: LR was thanked for the update, and the Quality Committee noted the report.

WELL-LED

203/21 GETTING IT RIGHT FIRST TIME (GIRFT) REPORT

Dr Cornelle Parker presented appendix F and acknowledged the authors of the report who form the GIRFT core team.

The report details the Trust's position, exemplar recognition and partnership working with the National GIRFT team on several initiatives and new developments, sharing practice and reporting. Some challenges for the GIRFT team were raised, including the departure of the Chief Executive, who had a very strong, visible and personal commitment through direct support and regular meetings with the Team, which will need to carry on going forward. The second challenge is the time commitment in relation to GIRFT. For the first two years of the programme, there was some backfill which is no longer available, which becomes a challenge given the expanding national role. The team are currently reviewing the time commitment to the programme, which will require resourcing, if this is to be prioritised going forward.

KH reported on the great work which would be a shame to lose, particularly now with national recognition. KH stated that the work is an absolute credit to CP and GIRFT colleagues.

ES queried whether data from the model hospital is used, as well as GIRFT data, as they have similar benchmarking across different clinical themes and specialities. CP stated that GIRFT now reports through the model hospital in terms of its metrics, however, not reliably, and therefore, should be a wider discussion on how business intelligence is used, particularly around things like model hospital.

DB commented on the well-developed and robust approach to the GIRFT programme, which is recognised nationally, however, it was noted that the outcomes of the process for CHFT were missing from the report, for example, the quality improvements, the efficiency improvements that have been a result of the investments and the work carried out. CP stated that a selection of the quality improvement benefits gained from those action plans can be provided.
Action: That an update is provided in January 2022 on the outcomes of the process.

The Chair queried whether there would be an issue with resourcing to the level that is required to continue the programme, now that CHFT is one of the two leading trusts in the country. CP stated that this would be dependent on how much of a priority the programme is with the arrival of the new Chief Executive from January 2022.

OUTCOME: CP was thanked for the report, which the Quality Committee noted.

204/21 BOARD ASSURANCE FRAMEWORK RISK 6/19 – COMPLIANCE WITH QUALITY AND SAFETY STANDARDS

Ellen Armistead presented appendix G, providing assurance on the updated deep dive of the board assurance framework risk 6/19 on compliance with quality and safety standards.

The risk articulation and impact remain relevant as an accurate description of the risk and reflective of the current position. The key controls have been reviewed and updated to include:

- Quality Governance structure – this has been reviewed and recruitment to key posts are underway. Gaps in current managerial structure now filled.
- Learning and Improving - Quality and Safety Strategy agreed and implemented.
- Journey to Outstanding (clinical area accreditation) is underway with further rollout planned.
- Care of the acutely ill patient (CAIP) programme is underway and has dedicated clinical leadership to oversee delivery.

Positive assurances remain relevant, however, in terms of gaps in controls, there remains a risk in relation to the capacity of serious incident investigators (SI) to undertake a review in a timely manner. This was a problem pre-COVID and has been exacerbated by the need for operational and clinical frontline staff for clinical operational priorities. There has been some increase in capacity within the corporate team to support some of the SI investigation. The risk rating has been reviewed and remains at a score of 12.

OUTCOME: EA was thanked for the review, and the Quality Committee noted the report.

EFFECTIVE

205/21 CLINICAL OUTCOMES GROUP UPDATE

Prior to the verbal update from Dr David Birkenhead, some clarity on the requirements of the Quality Committee from the Clinical Outcomes Group (COG) was requested. DB stated that the COG meets monthly and may not be sufficient enough to provide a full report for the committee on a monthly basis. DB queried whether the minutes and any escalation items to the Committee would suffice, with a 6-month report being provided on progress within the COG. The Chair agreed with the revised way of reporting.

In relation to the two previous COG meetings, there were no escalations into Quality Committee, however, the work done by the dementia team was highlighted. Work on the dementia scores have started to show some improvements, which will hopefully continue, through focussed work from colleagues.

CP reported that the Care of the acutely ill patient (CAIP) programme is progressing well, with the establishment of six workstreams (sepsis; stroke; clinical coding; acute kidney injury;

deteriorating patient; and acuity on discharge) with three identified outcome measures for each, which are included on a dashboard which can be linked into quality priorities.

The Chair commented on the positive improvement around dementia screening and confirmed that the minutes from the COG will now be received into the Quality Committee going forward, along with any items of escalation.

OUTCOME: The Quality Committee received and noted the verbal update.

206/21 MEDICAL EXAMINER UPDATE

Dr Tim Jackson was in attendance to present appendix H, providing an update from the Medical Examiner (ME) service in the last six months.

TJ reported that overall activity is derived from data submitted on a quarterly basis to the national ME Office. CHFT consistently scrutinise a significant number of deaths, which varies from quarter to quarter, however, within the latest quarter, approximately 92% of cases were scrutinised, which is over the regional average. In terms of coroner referrals, between 10 and 12.5% were referred, which in comparison to regional figures, CHFT referrals are quite low. This needs to be understood a little better, as this may be partly due to the peculiarities of coroner referral patterns throughout the region.

The outcome of coroner referrals, Medical Certificate of Cause of Death (MCCD), registrar declined MCCD, contact with bereaved relatives and clinical governance outcomes of scrutiny were all detailed in the report.

In terms of future developments, there are still opportunities to:

- foster close working relationships between CHFT, the local authorities, registrars, and the coroner, in order to review and learn from notable cases;
- replicate that approach within CHFT to continue to strengthen support of the Learning from Death agenda, and ensure meaningful interaction with Datix, Structured Judgement Reviews, Patient Advice and Liaison Service and legal teams.
- begin to explore ways in which to describe mortality trends at an earlier stage.
- further develop the medical examiner team through expansion to accommodate the planned rollout into the wider community.

KH thanked TJ for the helpful detail within the report and stated that it would be interesting to see how the regional benchmarking progresses over time.

CP conveyed thanks to TJ and the ME team and stated that the reviews are of value as mortality reports tend to be a month in arrears. Further conversation is required about how coroner benefits to the organisation are mapped, as the number of referrals to the coroner's office and the number of cases that the coroner chooses to pursue through inquest and potentially litigation, are all measurable. CP stated that these measures would also be interesting to track over a period of time.

CP noted that the Community rollout may be very challenging from a digital and cultural perspective, and that support for the team will be required in pursuing that.

The Chair thanked TJ for the useful reporting update and asked if there were any opportunities to network and share experience and learning across the region. TJ reported that ME offices network on a monthly basis, and are regularly in touch with neighbouring trust colleagues, who can readily 'go see'.

OUTCOME: The Quality Committee conveyed thanks to TJ and the team on the significant amount of work done in the last 11 months.

RESPONSIVE

207/21 INTEGRATED BOARD REPORT

Lindsay Rudge reported on appendix I, and the Trust performance for September 2021 of 66.4%, which is a significant deterioration on the August position, with the key changes in complaints, Summary Hospital-level Mortality Indicator and stroke.

The strengths within the report were acknowledged; the continued focus on elective patients, particularly those with learning disabilities, P2s and the longer waiters; the workforce development programme done around theatres; the community pharmacy roles on medicines safety; support offered to partner organisations for non-surgical oncology; the digital virtual consultations trialled in the emergency department; the initial focus on clinical validation and the recovery framework.

The challenges in the workforce position were discussed in detail at the Workforce Committee, as well as the short-term sickness position, which was at its highest position since November 2020.

LR drew the Committee's attention to the tier-4 beds around Children and Adolescent Mental Health Services (CAMHS), where there are several patients have been waiting for a significant time. It was noted that this has been escalated to and acknowledged by the Medical Director at South West Yorkshire Partnership Trust.

LR noted some positive outcomes from patients, and benchmarking analysis within the report with strong performances from CHFT against a number of selected indicators.

The report describes the triangulation of the metrics and the ongoing challenges around nurse staffing levels. LR also highlighted that outside of the integrated performance report, enhanced monitoring is in place through an extended weekly gold meeting which reviews metrics from an established dashboard and triangulates quality and safety indicators against 'must dos' and maps those against a trigger of enhanced monitoring outside of normal monitoring processes, which will link to the opal framework. This will be discussed at the next Committee in further detail, in order for members to be are aware of the process that is in place.

CP commented on stroke measures and several issues where the proportion of stroke patients being managed in dedicated stroke beds is deteriorating, which relates to capacity pressures. A dedicated bed base is being developed for stroke admissions in order for those patients to be moved directly from the emergency department into the stroke beds, regardless of their need for thrombolysis.

CP mentioned that the measures within stroke - the imaging within an hour and thrombolysis within an hour - have also deteriorated, particularly the thrombolysis measure. Both measures are incorporated into the Care of the acutely ill patient (CAIP) programme and being reviewed. DB reported on a work together get results (WTGR) process with the stroke team to progress a more resilient approach to stroke, developing action plans for change which will get the bed base right and ensure patients can be placed directly into stroke beds, and manage the thrombolysis issue.

CP also mentioned that the Summary Hospital-level Mortality Indicator has deteriorated to 101.91 and is very difficult to understand why at this point in time.

LR reported that a meeting with NHS England/Improvement on CHFTs current outbreak and hospital onset COVID infections will be taking place this week with the infection control team, to understand if anything is required to be undertaken to mitigate the current position.

The Chair noted the increase in falls with harm since the last report and asked if the training which needs to take place will be difficult. LR reported that CHFT have received some falls

alarms which require colleagues to be trained across a number of areas in order to deploy the alarms. A specific target needs to be met before the alarms can be deployed as part of medical device and safety regulations. Some focused training will be carried out in areas with the highest incidence of falls, in order for the equipment to be deployed. Significant improvements have been made, and where there is 90% compliance, a pragmatic decision has been taken to deploy the devices. Where a colleague may not be trained in the ward area, in-situ training will be undertaken on the day. The colleague will not use the device, but will be trained to use the device, rather than delay the devices going onto those clinical areas. Progress will be reviewed on a weekly basis through the enhanced clinical dashboard. Through the CQC and Compliance Group, agreement was made for a review of medical devices, the training, and the level at which the training is set, to understand where there are significant gaps.

The Chair noted capacity issues, social care packages and discharge to assess beds, etc. LR stated that a quality review meeting took place with Clinical Commissioning Group (CCG) colleagues, which will be followed-up at a systemwide clinical quality board meeting this week for further discussion. CP reported that local authority representation from both authorities will attend the gold meeting, where a direct conversation can be taken around delayed transfers of care.

OUTCOME: LR was thanked for the update and the Quality Committee noted the report.

208/21 CANCER BOARD MINUTES

A copy of the minutes from the Cancer Board meeting on 13 October 2021 were available at appendix J for information.

POST MEETING REVIEW

209/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

In terms of escalation to the Board of Directors, the Quality Committee notes receipt of:

- the maternity overview report and the work ongoing following further guidance received
- an update on the mandated patient safety specialist role
- an updated board assurance framework risk 6/19 on compliance with quality and safety standards
- the Medical Examiner report and the significant progress made over the last 11 months
- the integrated performance report
- the quality meeting which took place with the CCG, partner organisations and both local authorities in attendance

210/21 REVIEW OF MEETING

The following comments were noted:

- *'the Committee had discussions which were appropriate to agenda items'*
- *'positive reports which demonstrated good progress over a period of time'*
- *'good triangulation with the integrated performance report'*
- *'detailed reports with a great level of discussion'*
- *'some positive reports but also recognition where additional assurance is required'*
- *'really focused papers, good insights highlighted'*
- *'very helpful concise reports which show the impact of work being undertaken'*

211/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

212/21 QUALITY COMMITTEE ANNUAL REPORT

A copy of the annual report was available at appendix K for information.

213/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix L for information.

NEXT MEETING

Monday, 6 December 2021	3:00 – 4:30 pm	Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 8 NOVEMBER 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
CURRENT ACTIONS				
11.10.21 (188/21)	**Integrated Performance Report**	**Pharmacy**	In relation to safeguarding, the Chair requested a report on medical reconciliation within 24 hours (excluding children), due to performance being in the red for the past 12 months. **Action**: A paper regarding performance on medical reconciliation within 24 hours and how to improve the position **Update**: It has transpired that medical reconciliation within 24 hours is an issue related to Pharmacy, not safeguarding. An update will be provided by Elisabeth Street at the next meeting in December 2021	**See agenda item 218/21**
UPCOMING ACTIONS				
08.11.21 (203/21)	**GIRFT**	**Dr Cornelle Parker**	It was noted that the outcomes of the process for CHFT were missing from the report, for example, the quality improvements, the efficiency improvements that have been a result of the investments and the work carried out. CP stated that a selection of the quality improvement benefits gained from those action plans can be provided. **Action**: That an update is provided in January 2022 on the outcomes of the process.	**DUE January 2022**
CLOSED ACTION				
11.10.21 (188/21)	**Integrated Performance Report**	**Risk Team**	The Chair asked whether the ring-fenced stroke bed in the emergency department is always accessible for stroke patients. LR stated that a pre-alert is received for stroke patients, and where possible, the bed is made available. There may be challenges at times due to current occupancy and demand through the emergency department, however, it may be worthwhile to know if there have been any incidents where the bed was not available and the impact that may have had. **Action**: To ascertain the impact of any incidents relating to the stroke bed in the emergency department not being available. **Update**: Lisa Cook visited the emergency department at Calderdale on 13th October 2021 and spoke with the matron about the stroke bed in the department, who confirmed there were no issues with the bed not being available and fed back that the pathway works really well. A search of incidents going back to January 2020 was carried out, with no incidents found relating to the stoke bed not being available. There were only 11 incidents in total that were in relation to stroke care.	**CLOSED 8 November 2021**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 6 December 2021

STANDING ITEMS

214/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Lisa Cook **(LC)**	Head of Risk and Compliance
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Enzani Nyatoro **(EN)**	Interim Assistant Director for Patient Safety
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Karen Spencer **(KS)**	Associate Director of Nursing – FSS Division
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / Greater Huddersfield / North Kirklees CCGs
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Katherine Cullen **(KC)**	Deputy Director of Pharmacy **(item 218/21)**
Jo Fawcus **(JF)**	Chief Operational Officer **(observing)**
Emma Housecroft **(EH)**	Quality Directorate Secretary **(observing)**
Philip Lewer **(PL)**	Chairman **(observing)**
Dr Elizabeth Loney **(EL)**	Associate Medical Director **(Item 219/21)**

215/21 APOLOGIES

Jo Kitchen	Staff Elected Governor
Dr Cornelle Parker **(CP)**	Deputy Medical Director

216/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

217/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 8 November 2021 were approved as a correct record. The action log can be found at the end of these minutes.

218/21 MATTERS ARISING

Katherine Cullen was in attendance to present the paper circulated at appendix C, to show performance on medicines reconciliation within 24 hours and how to improve the position.

The reality, result and response to medicines reconciliation, which was described as every patient having their medicines reconciled by a member of the pharmacy team, ideally within 24 hours of admission, was outlined in the report, with short, medium and long-term plans in place.

The Chair asked whether the safari scheme would help to release capacity for colleagues. **KC** stated that the safari scheme being piloted over the winter period, with a pharmacist

prescriber-led discharge team involved in the writing of TTO's (to take out), would potentially release the resource. In terms of the next six months, the validity of the data will require reviewing, however, with current resources and a lot of work to undertake, the 68% target within 24 hours should be able to be achieved.

LR asked whether there were any further digital platforms which would enable an improvement in medicines reconciliation. **KC** stated that limited access on the electronic patient record (EPR) to community records prevents this, however, permissions for the pharmacy team and junior doctors to have full access to SystmOne would mean getting information faster. It was stated that the barriers to this would need to be identified. **ES** stated that a lot of work has been ongoing and a further update on progress will be provided in the next six months.

OUTCOME: **KC** was thanked for the update and the Quality Committee noted the report.

EFFECTIVE

219/21 CONSENT POLICY

Elizabeth Loney was in attendance to present the Consent Policy at appendix D.

EL noted that the Policy was circulated to various stakeholders, including the Clinical Ethics Panel, the Patient Experience and Caring Group, Divisional Directors, the Risk Management and Legal team. The Policy was rewritten for an easier read, in language that was easy to understand, and to also incorporate the General Medical Council (GMC) guidance which was published in 2020. The comprehensive document covers different aspects but does not include consent requirements for procedures including research, use of tissues under the Human Tissue Act (2004) / for transplantation, and gamete storage/ retrieval.

The Chair noted the comprehensive policy, and consulted with the Quality Committee for the Policy to be taken to the next stage,

OUTCOME: **EL** was thanked for the Policy, which the Quality Committee approved.

SAFE

220/21 MATERNITY SERVICES REPORT

Karen Spencer was in attendance to present the maternity services stillbirth review at appendix E.

The report described an increase in the number of stillbirths at CHFT, and reviews undertaken to identify the risk factors which influenced the increased rate.

Assurance was provided that a full review of the care following any stillbirth or neonatal death within maternity services is undertaken and shared at divisional orange incident panel review meetings and are reported nationally via the Perinatal Mortality Review tool and any cases that would meet the criteria for Healthcare Safety Investigation Branch (HSIB) investigation are identified. All policies and guidelines have been reviewed and assured that everything in place is compliant with current NICE guidance. It is identified that work is required on the triangulation of data in terms of IMD codes, smoking and ethnicity, and this is work which is ongoing.

GC asked whether there was a date for the region wide review, however, no date has yet been provided for this. **GC** also asked whether it was possible to reflect the women's voices on whether there was anything which they felt could have been done differently. **KS** stated that if any reviews uncover concerns about failings in care, it is ensured that as part of duty of candour, women's voices and any questions from families are included in any complaint response. All women and families who suffer a loss are offered follow-up with the bereavement

midwife, which is available for as long as the family require. Another piece of work being done is the role of the sudden and unexpected death in children (SUDIC) coordinator, to support women's and children's services, neonatal services, and to work with the bereavement midwife.

GC also asked whether the independent senior advocate role has been filled, as recommended in the Ockenden review. **KS** stated that the role has not been filled at CHFT, as well as other maternity services. CHFT is still awaiting national guidance on the role.

EL asked a series of questions including what gestational age babies were dying and whether there was a trend? What percentage of those children might have been expected to die if their fetal anomalies were so significantly severe? How much extra risk does being diabetic give a patient of having a stillbirth; are CHFT numbers consistent with the diabetic population, and how is CHFT benchmarking against these risks?

KS stated that the babies mentioned as part of the report are all beyond the stage of viability of 24 weeks gestation. **KS** also stated that the time at which babies die often depends on what is wrong with the baby. Some babies have a very complex congenital anomaly and some will die very shortly beyond 24 weeks, and others will last much longer. The patients who declined induction were both beyond their due dates and these were term babies. The six patients that had congenital abnormalities, three adopted for feticide. If it is highly likely that ladies who choose to terminate pregnancy for fetal abnormality, and there is any chance that the baby will be born alive, the fetal medicine unit at Leeds does recommend feticide. The reason for that is that termination of pregnancy is not intended to result in a live birth. Of the three ladies who chose to terminate their pregnancy, two of those had rare congenital abnormalities related to formation and development of the brain, and one for a recognised genetic abnormality. Of the three ladies who had genetic abnormalities but chose to continue with their pregnancy, two of those were related to abnormal development of the brain, and one of those babies had a rare congenital abnormality, however, the family carried a recessive gene, so they knew, and had other pregnancies that were similarly affected.

In terms of the percentage of diabetic women, this is a piece of wider work required to triangulate data, as it is not known whether the diabetic women who live in areas of deprivation are from Black, Asian and Minority Ethnic (BAME) communities, as nationally, it is not particularly well-reported. The MBRRACE (Mothers and Babies: reducing risk through audits and confidential enquiries) report looks at a link between ethnicity and social deprivation and smoking, rather than specifics of numbers of diabetic women nationally and percentage of those that pass away. Nevertheless, some of these percentages are quite large. The cases that CHFT had were 0.91%, less than 1% of our birth rate, which is just short of 5,000 births per year. It is very difficult, as a Trust, to statistically pick anything out from those small numbers, which is why the piece of work across the region is being done as a totality.

LR noted the health inequality work that both the organisation and the region are looking at, and the important work being undertaken by midwives within the workforce. **KS** shared some of the initiatives being undertaken, including:

- The public health midwife being involved in a piece of work, particularly with Kirklees local authority, to support the stop smoking services for pregnant women, and some of the very brief advice in early intervention work.
- A piece of work being done on women's experience during COVID-19. Work with colleagues from the Mid Yorkshire Hospitals NHS Trust and Huddersfield University has been done to translate maternity care information leaflets into commonly-used languages, using local maternity system monies. Work with Bradford has produced a diabetes animation around being healthy with diabetes in pregnancy and is available in multiple languages.
- Women now being able to access electronic maternity records remotely via their devices. A health education and information platform is available with health information leaflets and advice on anything pregnancy-related.
- The reinstating of parent education classes using virtual technology and social distancing.

- Work being done, cognisant that continuity of carer (COC) and one-to-one care for women is still a priority for maternity services, on looking at other roles which can be used in as an adjunct to midwifery care to deliver more of the health education and healthy living advice. Two COC teams - one based at the Jubilee Centre in Halifax and the other at the Chestnut Centre in Huddersfield – are in areas with high numbers of BAME women.

The Chair noted the fetal growth in pregnancy and the fact that quite a percentage were missed with multifactorial reasons why. In terms of moving forward, it was asked if there were any particular changes to practice that may increase the percentage of measurements of fetal growth. **KS** stated that once babies that were small in previous pregnancies have been identified, then serial growth scans can be put in place for those women. As far as abdominal palpation, there are a lot of factors to take into. In an ideal world, it would be the same midwife examining the same woman each time, and the only way to absolutely identify this is to scan every woman at every antenatal appointment, however, this is not without risk, and also the resource is not available to carry that out.

The Chair noted the important report which provided an in-depth discussion on progress and asked for a future update.

OUTCOME: **KS** was thanked for the report, which the Quality Committee noted.

221/21 TRUST PATIENT SAFETY AND QUALTIY BOARD (PSQB) REPORT

Enzani Nyatoro presented appendix F, highlighting work undertaken in the Trust Patient Safety and Quality Board (PSQB) during July to September 2021.

Sub-group reports were received from the Medication Safety and Compliance Group and Resuscitation Committee. It was noted that drug errors in terms of discharges, mentioned in the Medication Safety and Compliance Group report will be picked up again, as this is a consistent theme. Most of the issues identified from the Resuscitation report have now been resolved, except for the issue in relation to basic life support training, where 1800 colleagues did not attend sessions during April 2020 to March 2021. This will be picked up again with the Resuscitation Committee regarding what mitigations are in place.

Updates were received on the patient safety alerts, two of which have been outstanding for some time. The Central Alert Systems (CAS) process and Policy are being reviewed to ensure clear responsibilities within the process. The two outstanding alerts were:

- *Ligature and ligature point risk assessment tools and policies* – the task and finish group arranged to implement this alert is now almost complete, with a risk assessment tool circulated to ward areas, and positive feedback received.
- *Steroid emergency card to support early recognition and treatment of adrenal crisis in adults* - this is currently in the process of being completed. A standard operating procedure has been produced, and a risk identified.

Deep dives were carried out on safeguarding and appointment/admission/transfer/discharge incidents. The medication errors mentioned earlier feed into safeguarding and discharge incidents. There is a need to review the discharge process which is multifaceted and can involve the availability of equipment, implications for safeguarding and medication administration. From a patient safety perspective, this is an area which needs review to ensure patients are safe and to triangulate the learning.

Items for escalation to the Quality Committee detailed in the report included endoscopy patient cases in the surgical division; a possible rise in safeguarding incidents, with a possible indicator of harm to patients; an increase in emergency callouts and workloads in the Community, leading to increased volume, and staffing pressures.

Next steps for the Trust PSQB are to create a Trust safety bulletin with key messages on information learned from triangulating incidents can be circulated to colleagues.

In terms of the basic life support training, **LR** stated a piece of work has been commissioned to look at a training plan funded through central monies, which will bring the training compliance figures back to where they should be.

LR also noted that the risk assessment for the patient safety alert on ligature and ligature point risk assessment tools and policies should be implemented and rolled out by today. In relation to the deep dives, **LR** stated that it would be helpful to highlight the responsible and accountable group or committee within our governance structure, that have oversight of the actions identified, which would strengthen closing the loop. In relation to the patient safety alert on steroid emergency card to support early recognition and treatment of adrenal crisis in adults, **LR** asked if a 'go see' to other organisations has taken place to see how they are responding to the alert. **ES** stated that the alert has been discussed at Medication Safety Officer (MSO) networks, with other Trusts having difficulty implementing the alert. **ES** also stated that there has been an issue with engagement from the divisions in relation to this alert. **LR** stated that greater clarity is required on the next steps of the patient safety alerts, and that the process around the Central Alert System (CAS) alerts is currently being reviewed by the Risk management team. An update on progress was asked to be provided at the next meeting.
Action: That an update on the CAS process is provided at the next meeting.

In terms of the community responses, **LR** stated that it would be useful for the Quality Committee to have an update and context on the new urgent responsive model that Community are rolling out and implementing.
Action: For the new Community model to be an agenda item at a future meeting.

OUTCOME: **EN** was thanked for the update and the Quality Committee noted the report.

WELL-LED

222/21 BOARD ASSURANCE FRAMEWORK RISK 4/20 – CQC RATING

Lindsay Rudge presented appendix G, providing assurance on the updated deep dive of the board assurance framework risk 4/20 relating to CQC rating.

The risk articulation and impact remain an accurate reflection of the risk. The key controls were reviewed and updated, and the risk remains at a score of 16 due to the current areas of non-compliance and the ongoing work required.

OUTCOME: **LR** was thanked for the review, and the Quality Committee noted the report.

RESPONSIVE

223/21 INTEGRATED BOARD REPORT

Lindsay Rudge reported on appendix H, and the Trust performance for October 2021 of 64.6%, which was an improvement on the September position which had deteriorated further following the inclusion of the latest national friends and family test (FFT) targets and a late cancer 31-day breach. As a result, the responsive domain was in the red in September, which has now recovered to amber.

Areas of concern which are currently red are complaints, diagnostics 6 weeks, cancer at 62 days, the emergency care standard and sickness. There are challenges in complaints, dementia screening, and fractured neck of femur, with specific work ongoing to ensure that dementia screening takes place. The strength, weakness, opportunity and threat (SWOT) analysis continues to describe the elective recovery programme as a strength, in terms of the work ongoing, particularly around health inequalities and prioritisation. There are still increased attendances through the emergency department, and the SAFER programme continues to be rolled out with a significant focus around plan for every patient. In terms of the quality priorities, there was a decreased level of performance, particularly around the recognition of sepsis. There were a number of Clostridium difficile infections, with a breach in

target for this year. There was also an increase in the amount of Hospital-Onset COVID-19 Infections (HOCIs) during the reporting period, with increased emergency department (ED) waits of more than eight and 10 hours, as well as an increase in falls. There was a deteriorating position on ward assurance, as well as a number of category 4 pressure ulcers. In terms of mortality, Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) have increased slightly, with further work being done to understand why this happened. The long list of quality priorities for the coming year are also being produced, however, some of the current priorities may continue.

In relation to urgent care and cancer, **JF** stated that work is ongoing with teams to improve the streaming and triage processes across urgent care, in light of the long ambulance waits seen in October. Numbers through the emergency department fluctuate and is expected to increase. In relation to the 62-day screening standard for cancer, this is being monitored, and it is hoped to improve this month.

In relation to the infection, prevention and control metrics, **DB** stated that they are performing reasonably well. Last year, the Trust breached the ceiling for Clostridium difficile, and analysis suggests this was due to COVID and broad spectrum antibiotics being used as a result of respiratory tract infections. Most of the Clostridium difficile cases are isolated and not linked to outbreaks. There have also been a number of HOCI cases, with data suggesting that hospital transmission of COVID reflects community transmission. There has not been any infections in the last few weeks, which is an improving position.

OUTCOME: **LR, JF** and **DB** were thanked for their updates and the Quality Committee noted the report.

POST MEETING REVIEW

224/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

In terms of escalation to the Board of Directors, the Quality Committee notes receipt of:

- the comprehensive Consent Policy
- the maternity report on stillbirths
- an updated board assurance framework risk 4/20 on CQC rating – score remains at 16
- the key issues from the integrated performance report, with reduced performance in quality priorities for sepsis; the breach in the Clostridium difficile target, increase in category 4 pressure ulcers; update on the infection prevention adn control position

225/21 REVIEW OF MEETING

- Reports made easier to read due to abbreviations being explained

226/21 ANY OTHER BUSINESS

Going forward, **JF** mentioned that assurances on the pressures to urgent care on ambulance waits, waits for beds and how they triangulate with the quality standards, will be provided to the Committee in the future.

ITEMS TO RECEIVE AND NOTE

227/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix I for information.

NEXT MEETING

Wednesday, 5 January 2022 3:00 – 4:30 pm Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 6 DECEMBER 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
CURRENT ACTIONS				
08.11.21 (203/21)	**GIRFT**	**Dr Cornelle Parker**	It was noted that the outcomes of the process for CHFT were missing from the report, for example, the quality improvements, the efficiency improvements that have been a result of the investments and the work carried out. CP stated that a selection of the quality improvement benefits gained from those action plans can be provided. **Action**: That an update is provided in January 2022 on the outcomes of the process.	**See agenda item 05/22**
UPCOMING ACTIONS				
11.10.21 (221/21)	**Trust PSQB Report - Central Alert System (CAS) process**	**Head of Risk and Compliance / Assistant Director of Quality and Safety**	The process around the Central Alert System (CAS) alerts is currently being reviewed by the Risk management team. An update on progress was asked to be provided at the next meeting. **Action**: That an update on the CAS process is provided at the next meeting.	
11.10.21 (221/21)	**Trust PSQB Report - Community**	**TBC**	In terms of the community responses, it was stated that it would be useful for the Quality Committee to have an update and context on the new urgent responsive model that Community are rolling out and implementing. **Action**: For the new Community model to be an agenda item at a future meeting.	
CLOSED ACTION				
11.10.21 (188/21)	**Integrated Performance Report**	**Pharmacy**	In relation to safeguarding, the Chair requested a report on medical reconciliation within 24 hours (excluding children), due to performance being in the red for the past 12 months. **Action**: A paper regarding performance on medical reconciliation within 24 hours and how to improve the position **Nov Update**: It has transpired that medical reconciliation within 24 hours is an issue related to Pharmacy, not safeguarding. An update will be provided by Elisabeth Street at the next meeting in December 2021 **Dec update**: See agenda item 218/21	**CLOSED December 2021**

Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE – DEEP DIVE

Held on Monday 8 November 2021, 10.30am – 12.30pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
Peter Bamber	(PB)	Governor
David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Andrea McCourt	(AM)	Company Secretary
Lindsay Rudge	(LR)	Director of Nursing
Helen Senior	(HS)	Staff Side Chair
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Anna Basford	(AB)	Director of Transformation and Partnerships (for agenda item 14/21)
Leigh-Anne Hardwick	(LAH)	HR Business Partner (for agenda item 108/21)
Liam Whitehead	(ML)	Employability Manager (for agenda item 112/21)
Agnieszka Wozniak	(AW)	Director of Medical Education (for agenda items 110/21)

103/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting. Welcomed PB to his first meeting.

104/21 **APOLOGIES FOR ABSENCE**

No apologies were received.

105/21 **DECLARATION OF INTERESTS**

There were no declarations of interest.

106/21 **MINUTES OF MEETING HELD ON 30 SEPTEMBER 2021**

The minutes of the Workforce Committee held on 30 September 2021 were approved as a correct record.

107/21 **ACTION LOG – November 2021**

The action log, as at 8 November 2021, was received.

108/21 **MATTERS ARISING**

DEEP DIVE INTO ESTATES AND ANCILLARY SICKNESS ABSENCE

LAH presented a deep dive detailing sickness absence in the Estates and Ancillary staff group. This staff group represents 64 roles in the organisation all of which are housekeepers with 50% of colleagues being employed in the Medicine Division. Key headlines were:-

- November 2020 saw the highest total absence of 10.79% (159.88 FTE), followed by March 2021 with 10.57% (157.76 FTE). Steady increase from September 2020 to April 2021, with a small decline in December 2021, for Long Term Absence.

- Most absences occurred in March 2021 with a total of 17. October and November 2020 saw the most occurrences for short term absences. March 2021 saw the most occurrences for long term absences.

- From September 2020, long term sickness has slowly increased, with two dips in December 2020 and March 2021. In January 2021 there were 4 long term sickness absences, which then doubled in March 2021 to 8 staff members. From May 2021, long term sickness has started to decrease.

- Top three absence reasons are Anxiety/Stress/Depression/other psychiatric illnesses, Nervous System disorders and Chest & Respiratory problems.

SD queried if there were any repeat isolations in this group and also sought assurance the right support is being offered. LAH confirmed the HR operational team will examine the deep dive data to better understand the absence reasons and determine any alternative support measures that would target that group of staff in a different way. DS asked about the hot spots. LAH advised of a specific piece of work in medicine being undertaken to provide additional support to help manage attendance. LR confirmed the number of colleagues deployed on a weekly basis is analysed. LR referenced the active recruitment of additional housekeepers and highlighted the importance of tackling any key themes to prevent early absence in a group of new recruits.

KH commented on the high number of FTE days lost. LAH confirmed a stringent data set is followed and continuous focus given to long term sickness absence. KH asked if absence cover is provided for this staff group. LR advised that this is an area which needs to be re-visited.

PB questioned what methods are used to measure and ensure IPC cleanliness against housekeeping absence. LR confirmed there is an established housekeeper forum and in addition DB explained IPC procedures and mechanisms in place to tackle issues.

KH thanked LAH for this detailed piece of work.

OUTCOME: The Committee **NOTED** the report.

109/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – OCTOBER 2021**

MB presented the report.

Summary
Performance on workforce metrics is now amber and the Workforce domain at 63.0% in September 2021. This has remained in the amber position for a third month. 5 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', short Term Sickness Absence rate (rolling 12 moths) and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)', and Data Security Awareness EST compliance. Medical appraisals are currently not included in the overall Domain score due to the current Covid-19 pandemic, and Non-medical are not included as the appraisal season is extended to March 2022.

Workforce – September 2021
The Staff in Post increased by 59.37 FTE, which, is due, in part to 28.58 FTE leavers in September 2021. FTE in the Establishment figure increased by 4.93, along with student nurses leaving.

Turnover decreased to 7.74% for the rolling 12 month period October 2020 to September 2021. This is a slight decrease on the figure of 7.98% for August 2021.

Sickness absence – September 2021
The in-month sickness absence increased to 5.59% in September 2021. The rolling 12 month rate also increased marginally for the twenty fourth consecutive time in 34 months, to 4.89%.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 31.16% of sickness absence in September 2021, decreasing from 35.73% in August 2021.

The RTW completion rate increased to 66.83% in September, up from 60.26% in August 2021. This is the first consecutive monthly increase however is still is below target.
**(The RTW compliance position reported reflects activity data held in ESR as at 18 October 2021.*

Essential Safety Training – September 2021
Performance has decreased in 4 of the core suite of essential safety training with 10 out of 10 above the 90% target and 2 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance decreased to 93.81% and is the third decrease for 3 months. It is however still also above the stretch target of 95.00%.

Workforce Spend – September 2021
Agency spend increased to £0.54M, whilst bank spend decreased by £0.019M to £3.42M.

Recruitment – September 2021
1 of the 5 recruitment metrics reported (Unconditional Offer to Acceptance) improved in September 2021. The time for Unconditional offer to Acceptance in September 2021 decreased and was just under 1 day.

KH noted sickness absence affecting bank and agency costs. KH was pleased to see an increase in headcount along with turnover remaining below 8% and vacancy rate below 3%. KH hoped to see an improvement in EST.

OUTCOME: The Committee **NOTED** the report.

110/21 **GMC NATIONAL SURVEY OF TRAINEE DOCTORS 2021**

AG presented the results of the 2021 GMC national survey of trainee doctors that took place between 21 April 2021 and 25 May 2021. The Committee noted due to the pandemic 2019 results are being used by the GMC as a comparator.

Headlines of the survey results were:-

- CHFT response rate was once again 100% (highest in region for the 8th year in a row); national response rate was 76%.
- Our overall satisfaction score is 76.02. We are 6th highest in terms of overall satisfaction regionally (5th in 2019). Ahead of us are Sheffield Children's Hospital (81.89), Leeds Teaching Hospitals NHS Trust (78.78), Sheffield Teaching Hospitals (77.81), Harrogate and District NHS Foundation Trust (77.20) and York Teaching Hospitals NHS Foundation Trust (76.03).
- Overall satisfaction remained at pre-pandemic level, as did clinical supervision, teamwork and educational governance.
- Compared to 2019 improvement was seen in out of hours clinical supervision, reporting systems and educational governance.

- Categories for adequate experience, curriculum coverage and local teaching have seen the greatest negative impact.
- Very positive outcomes were seen in Acute Common Stem, a programme run across Emergency Medicine, Anaesthetics and Acute Medicine. Surgery achieved very significant improvement in most domains. Emergency Medicine is one area impacted mostly by the pandemic. Excellent reports in previous years, still performs solidly in the middle quartile across most domains and programmes.
- Satisfactory results were seen in obstetrics and gynaecology and trauma and orthopaedics, General Internal and Acute Internal Medicine
- Previous poor outcomes that noted improvement in this survey are respiratory, geriatric medicine and haematology.
- New and remaining areas of concern are Anaesthetics, Cardiology, Ophthalmology and Paediatrics

The report stated a significant number of doctors across the region were temporarily redeployed to medicine or critical care and there was also the effect upon those doctors who were unable to gain skills and knowledge required for their training programme due to cancellation of clinics, theatre lists and elective work. A third of trainees told the GMC they felt burnt out to a high or very high degree because of their work, as did a quarter of secondary care trainers and more than a fifth of GP trainers.

AG confirmed that a comprehensive action plan is being developed for all specialties. The feedback from the survey will also feed into the training recovery programme being devised for doctors in training. Delivery improvement plans would be monitored by the Education Committee.

DS queried the position on protected time for educational leads. AG advised of the challenges clinical colleagues face, some having relinquished their educational role and others not able to provide the time due to extra clinical work. DB acknowledged the impact to trainees and recognises that CHFT doesn't offer as much clinical educator time as the national contract at present due to insufficient medical capacity, additionally there are no educational opportunities for trainees in private facilities. SD suggested regular health and wellbeing 'lite' risk assessments could help track individual's journey at CHFT.

KH was pleased to note the 100% response rate. KH thanked AG for the detailed report along with the additional presentation for clarity.

OUTCOME: The Committee **NOTED** the report and would **RECEIVE** further updates via the Education Committee.

111/21 **MEDICAL WORKFORCE PROGRAMME**

DB presented a report which described the current medical workforce establishment at CHFT and measures being taken to address medical staffing risk. Budget resets from April 2021 have led to an increase in the Medical and Dental establishment from an overall total of 651 FTE in 2020/21 to 690 in 2021/22. The largest increase is at consultant level, which has expanded from 275 FTE to 293 FTE. Currently there are 51.6 vacancies and 91.4 posts progressing through the recruitment journey. DB described the key workstreams to strengthen the medical workforce along with the ongoing work to develop our own workforce, for example the CESR programme.

The Committee noted the pandemic's impact on sickness absence. DB commended the work of Cornelle Parker and Sree Tumula in planning and response to the pandemic.

KH thanked DB for the report and recognised the challenges and supported the alternative approaches to mitigate the medical workforce gaps. DB also wished to acknowledge the contribution from Lisa Cooper and Pauline North.

OUTCOME: The Committee **NOTED** the report

112/21 **EMPLOYABILITY UPDATE**

LW gave a detailed presentation on progress, partnership development and upcoming priorities for Employability. LW explained six clear priorities have been identified and described the elements involved in each:-

- Work Experience
- Pre-Employment Programmes
- T Level Cadets
- The Care Club
- Apprenticeships
- CHFT Employability Hub

LW highlighted in particular the national government funding programme – Kickstart, advising that six month contracts have been secured to recruit 20 young, unemployed adults across the Trust, equating to £115k/13,000 hours. LW explained more about the Volunteer Strategy and was also pleased to confirm a successful bid of £25k to support the volunteer project. 47 volunteers have re-commenced in the Trust since October following careful evaluation of safety compliance.

JE recognised the significant impact to date and exciting work being led by LW and the team. KH congratulated LW on the work and acknowledged the great contribution to the community.

OUTCOME: The Committee **NOTED** the report and a further update would be presented to a future Committee.

113/21 **BOARD ASSURANCE FRAMEWORK**
RECRUITMENT/RETENTION INCLUSIVE LEADERSHIP

SD presented a deep dive into BAF risk 11/19, risk of not attracting, retaining and developing colleagues to deliver one culture of care. Key controls have been reviewed and updated to include further key elements. SD in particular highlighted the following:-

- A Board agreed Succession Planning approach in place for Board of Directors
- The approach is being rolled out in each Division which links to a co-ordinated talent management pipeline programme
- Recruitment micro website now 'live' which will help attract and signpost a diverse pool of candidates expanding our reach to attract talent into the Trust.
- Clinical Director role review now complete with induction programme developed
- Development of 5 new career ladders for apprentices
- Wider strategy for Health and Wellbeing

Positive assurance included:-

- Apprenticeship services assessed as GOOD with one area of OUTSTANDING in July 2021
- CHuFT Awards Recognition programme, 130+ nominations from a range of grades, divisions and specialisms colleague to colleague nomination
- Integrated Performance Report and Workforce Committee reports show turnover rate at 7.98%

In terms of gaps in control, despite best efforts and increased scrutiny the combination of managing Covid positive and negative patients, increase in non-elective activity, staff

sickness (covid and non-covid related), elective recovery and a decrease in staff undertaking bank shifts is significantly impacting colleague and patient experience.

The Committee took note of a gap in assurance in relation to changes in pensions rules and the impact on higher earning and longer serving colleagues. A review of medical colleague turnover will take place following the issue of annual pension statements in October. SD confirmed Leeds TH have introduced a targeted recycling scheme to improve its waiting list. A position paper along with recommendations will be brought to the next Committee meeting.

The Risk Rating has been reviewed and remains the same.

OUTCOME: The Committee **NOTED** the report.

114/21 **BUSINESS BETTER THAN USUAL**

AB presented a high level summary of progress against each of the BBTU Themes for the period ending 30 September 2021. This report is also submitted to Finance and Performance Committee and Quality Committee.

The report highlights progress made against the 12 key learning themes. Of the 12 themes:

0 are rated red
5 are rated amber
6 are rated green
1 has been fully embedded

AB stated the embedded theme relates to the work around colleague wellbeing which had emphasis of learning from the pandemic to sustain ongoing and multiple ways of supporting colleague wellbeing and challenges. There is acceptance that colleague wellbeing is well embedded in our one culture of care approach.

Work is progressing on the 5 amber rated themes. AB highlighted the feedback from 1:1s, group meetings and surveys is being reviewed to support development of a working from home policy that will balance the needs of the organisation with colleague wellbeing and available estate utilisation. KH acknowledged the importance of the wellbeing agenda.

AB confirmed it was agreed at the November 2021 Board of Directors that a weekly meeting to be chaired by the Chief Executive would look at overall use of resources in the Trust.

OUTCOME: The Committee **NOTED** the report.

115/21 **WORKFORCE COMMITTEE WORKPLAN**

The workplan was received and reviewed.

116/21 **ANY OTHER BUSINESS**

No other business was discussed.

117/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

GMC National Survey
Medical Workforce Programme
Employability Update
BAF Risk, including sickness absence
Ancillary and Estates Deep dive Sickness Absence

118/21 **EVALUATION OF MEETING**

SD felt issues discussed were appropriate and timely.

PB felt some presentation slides contained too many tables and not easy to read.

119/21 **DATE AND TIME OF NEXT MEETING:**

10am – 12 noon: Workforce Committee Hot House – Review of the Cupboard
12:15 – 1.15pm: Workforce Committee – Review Quality & Performance Report (Workforce)

Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE – DEEP DIVE

Held on Monday 6 December 2021, 12.15pm – 1.15pm
VIA TEAMS

PRESENT:

Peter Bamber	(PB)	Governor
David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Karen Heaton	(KH)	Non-Executive Director (Chair)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Philip Lewer	(PL)	Chairman
Andrea McCourt	(AM)	Company Secretary
Lindsay Rudge	(LR)	Director of Nursing
David Simmons	(DS)	Staff Side Representative (attending for Helen Senior)
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Leigh-Anne Hardwick	(LAH)	HR Business Partner (for agenda item 127/21)
Andrea Gillespie	(AG)	Freedom to Speak Up Guardian (for agenda item 128/21)
Nikki Hosty	(NH)	Assistant Director of HR (for agenda item 129/21)

120/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

121/21 **APOLOGIES FOR ABSENCE**

Helen Senior, Staff Side Chair

122/21 **DECLARATION OF INTERESTS**

There were no declarations of interest.

123/21 **MINUTES OF MEETING HELD ON 8 NOVEMBER 2021**

The minutes of the Workforce Committee held on 8 November 2021 were approved as a correct record.

124/21 **ACTION LOG – December 2021**

The action log, as at 6 December 2021, was received.

125/21 **MATTERS ARISING**

Education Committee

JE presented a paper that set out the arrangements for a new Education Committee, reporting into the Workforce Committee. A core group was created to design the framework for the Education Committee. The terms of reference and guiding principles were shared with the Workforce Committee. The Education Committee will meet every 2 months, commencing January 2022 and provide a report to each Workforce Committee.

LR thanked JE for putting together the paper. DS was pleased to see that arrangements are in place and queried membership of the group in terms of representation of non-medical and non-nursing colleagues. JE explained that core membership was contained in the first instance in order to progress the work. Membership will continue to be reviewed and colleagues can be co-opted as the progress is challenged and tested. Pharmacy was cited as an example. KH questioned representation around the digital agenda. JE acknowledged the point and would take away for discussion and the terms of reference would be amended if required.

KH looked forward to seeing the forward plan that identified the focus of the group. JE explained good progress had been made in mapping education, training and development opportunities both internally and externally to ensure a comprehensive picture of workforce learning opportunities. KH asked how the Education Committee would connect to Executive Board. JE considered the link would be the Medical Director, Chief Nurse and Director of Workforce and OD to capture all roles.

In relation to the terms of reference, AM proposed that quorocy should be amended to read a specific number of attendees. The Terms of reference would be amended as such.

OUTCOME: The Committee **SUPPORTED** and **APPROVED** the establishment of a new Education Committee.

126/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – NOVEMBER 2021**

MB presented the report.

Summary
Performance on workforce metrics is now amber and the Workforce domain at 60.9% in October 2021. This has remained in the amber position for a fourth month. 5 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', short Term Sickness Absence rate (rolling 12 moths) and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)', and Data Security Awareness EST compliance. Medical appraisals are currently not included in the overall Domain score due to the current Covid-19 pandemic, and Non-medical are not included as the appraisal season is extended to March 2022.

Workforce – October 2021
The Staff in Post increased by 74.00 FTE, which, is due, in part to 36.52 FTE leavers in October 2021. FTE in the Establishment figure increased by 65.88, along with student nurses leaving.

Turnover increased to 7.89% for the rolling 12 month period November 2020 to October 2021. This is a slight increase on the figure of 7.74% for September 2021.

Sickness absence – October 2021
The in-month sickness absence increased to 5.74% in October 2021. The rolling 12 month rate also increased marginally for the twenty fifth consecutive time in 35 months, to 5.00%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 28.70% of sickness absence in October 2021, decreasing from 31.16% in September 2021.

The RTW completion rate decreased to 63.88% in October, down from 66.83% in September 2021. This is the third consecutive month under 65% (the second time in three months to be red) and is still is below target.

Essential Safety Training – October 2021
Performance has decreased in 8 of the core suite of essential safety training. With 9 out of 10 above the 90% target however only 1 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance decreased to 93.22% and is the fourth decrease for 4 months. It is however no longer above the stretch target of 95.00%.

Workforce Spend – October 2021
Agency spend increased to £0.55M, whilst bank spend decreased by £0.05M to £3.36M.

Recruitment – October 2021
4 of the 5 recruitment metrics reported (Unconditional Offer to Acceptance, Vacancy approval to advert placement, Interview to conditional offer, and Pre employment to unconditional offer) improved in October 2021. The time for Unconditional offer to Acceptance in October 2021 decreased and was just under 1 day.

KH noted that sickness levels are still of concern and that a steady increase is seen in the number of appraisals undertaken. RTW compliance has decreased and KH noted the input of HR to support managers. KH queried the high turnover rate in the admin and clerical group. A deep dive would be undertaken and presented to the next Committee meeting. DS was pleased to see the positives in the report, particularly the early adoption of the national specialist doctor terms and conditions in the Anaesthetics Department.

Action: Deep Dive into admin and clerical turnover position (MB).

OUTCOME: The Committee **NOTED** the report.

127/21 **VACANCY DEEP DIVE (QUARTER 2)**

LAH presented the Vacancy Deep Dive.

The Trust as at 30 September 2021 has 135.08 FTE budgeted vacancies. The planned position showed the Trust would be at 307.79 FTE vacancies at the end of September 2021. The over recruitment of HCSW in addition to the expected elevated levels of temporary bank/agency usage account for much of this difference.

The current medical and dental vacancy rate is less than 5% despite an increase in the budgeted establishment year on year. The establishment has steadily increased from 604 FTE in May 2016 to 677 FTE in May 2021, with a reduction in vacancies from 97 in May 2016 down to 49 in May 2021. The position has improved further from that date. Some specialties remain extremely difficult to appoint to, such as Emergency Medicine, Radiology and Stroke Medicine.

Workforce models had a 6 month review in July 2021. Data collection is currently underway to inform the workforce model reviews in January 2022. Local approach includes 4 rolling adverts for Staff Nurse Medicine; Staff Nurse Surgery; Return to Practice Nurse; and Nursing Associate. Over recruitment is planned in both ICU and endoscopy as these are areas which attract many applicants, allowing for both winter pressures staffing requirements to ICU as well as enhanced post-Covid reset activity in endoscopy. Recruitment of 68 new graduate nurses was successful in September. An accelerated programme of International Recruitment has committed to supporting 70 International Nurses during 2021. By the end of September 35 nurses had arrived in the UK. By the end of November 67 nurses will have arrived and a further 5 are planned to arrive during December. The additional recruits above 70 will contribute to our 2022 commitment to recruit 40 International Nurses, with a likely expansion to 80 before the end of 2022.

Monthly business intelligence reports provide data to inform our plans to recruit both international nurses and nursing associates. The weekly triangulation report is used to plan placement of these staff, into clinical areas with highest need and matched to the skill set of the nurse.

The Medical Division still has vacancy gaps to cover and is working at actively recruiting to roles especially the middle grade with Emergency Department and the Acute Respiratory Care Unit model to aid with recovery and sustainability to support our population with long Covid.

The Surgical Division is still carrying a number of vacancies. Rolling adverts are out and options for alternative roles continue to be explored. Approval has been secured for 2 Pharmacy Technicians to form part of the workforce model for Ward 11 as a trial and a dual Ward Clerk/Discharge Co-ordinator role is being explored. The recent jobs fair in theatres yielded 17 qualified appointees which is fantastic news.

FSS: Maternity - the team continues to move towards new models of working as part of the better births agenda and continuity of carer. Vacancy position includes the forecast of recruitment of additional midwives to workforce models in line with the Ockenden funding. Rolling adverts are in place for Paediatrics with over recruitment plans to enhance the workforce position. Gaps continue within phlebotomy due to turnover. New recruits tend to come through apprenticeships which see colleagues leave for further development opportunities. Work around a leadership structure has taken place and recruitment activity for this is underway.

Recruitment to new admin and clerical roles within the appointment centre is underway. The high number of vacancies within the Health Informatics service is being examined.

Campaigns supporting over recruitment have helped to stabilise the vacancy position across the AHP workforce.

LR confirmed the expansion to 80 international nurses has been approved. An update will be provided to a future Committee meeting following the workforce model review in January 2022.

DS asked for clarity around the Ockenden funding. LAH explained the additional funding is available for recruitment to the midwifery workforce model. However the challenge is in recruiting to the 10.9 additional posts. LR added the recruitment issue is across the wider local maternity services.

KH noted the significant achievements across the board and commended the continued efforts to fill vacancies.

OUTCOME: The Committee **NOTED** the report.

128/21 **FREEDOM TO SPEAK UP (FTSU) MID YEAR REPORT**

AG reported she was appointed as the Trust's FTSU Guardian in September 2021 and went on to present a paper that provides information regarding FTSU activity in the Trust from 1 April 2021 to 30 September 2021. The number of concerns reported anonymously remain high as in previous years and actions in response to the questionnaire completed by Board members in June 2021 are in progress. FTSU is included in the response to the One Culture of Care Winter Must Do.

On review of the concerns raised during Q1 and Q2 no specific common themes have been identified however the number of concerns raised anonymously is notable and suggests that colleagues might not feel safe to raise concerns confidentially or openly. Key messages of reassurance have been injected to comms and promotional materials.

KH reinforced the encouragement of colleagues to come forward. AM requested for comparison previous years' data is included in future mid-year reports. AM also referenced the case study shared and asked what the process is for identifying learning and how do we share that. AG stated a proportionate investigation is carried out in the first instance. Going forward a 'you said - we did' approach will be adopted, i.e. publicise examples of cases and what we've changed or improved. JE endorsed the FTSU annual report's importance of providing assurance to the Board that we are learning, renewing and refreshing processes and ensuring we are raising confidence in the organisation that people can raise concerns knowing we will respond and that they won't suffer any detriment as a consequence of raising those concerns. KH confirmed it helpful to have 6 month check in report.

OUTCOME: The Committee **NOTED** the report.

129/21 **EVOLVING THE CHFT WELLBEING PACKAGE**

NH talked through a presentation that updated the Committee on the approach to the 2022 wellbeing offer. The approach will underpin the current offer which recognises that colleagues are nearing mental and physical fatigue and enduring challenges such as personal and workplace bereavement. The pandemic has highlighted complex mental health issues for many colleagues. Feedback from colleagues identified that a quick route to help and advice is needed. Going forward there will be 2 clear access points for colleagues – wellbeing advisers and employer systems programme. Introduction of a leadership wellbeing programme will equip managers with the right skills and capabilities to support their own wellbeing and that of those around them. NH gave examples of qualitative and quantitative data that will be used to inform future activity.

KH congratulated NH and colleagues on the success and is interested to see measurement on outcomes and delivery of initiatives at a future meeting. A mid-year update is included in the Committee's workplan.

OUTCOME: The Committee **NOTED** the 2022 wellbeing package approach.

130/21 **BOARD ASSURANCE FRAMEWORK**
COLLEAGUE ENGAGEMENT

SD presented a deep dive into BAF risk 12.19 Colleague Engagement. Key controls have been reviewed alongside implementation of further projects and initiatives. SD in particular highlighted the following:-

- Inclusive talent management approach - Empower
- New wellbeing groups
- 24/7 helpline
- Hydration/nourishment bags delivered to colleagues
- Leadership support walkarounds
- FTSU

Positive assurance included:-

- Apprenticeship services assessed as GOOD with one area of OUTSTANDING in July 2021
- Root out racism campaign
- Bespoke wellbeing support packages for critical areas
- Turnover of 8%
- Enhance talent management programme

In terms of gaps in control, medical colleague turnover to be reviewed following the issue of annual pension statements in October 2021. An action survey of consultants will assess the impact. A paper will be brought to a future Committee meeting setting out the position and any recommendations if required.

The risk score remains at 12 having been increased from 9 in October 2021.

OUTCOME: The Committee **NOTED** the report.

131/21 **HOT HOUSE TOPICS**

The last two 2021 Hot Houses were stood down due to service pressures, the topics will be carried over into 2022.

Post meeting note

2022 topics are as follows:-

16 March: The CHFT colleague journey (building in our 2021 staff survey feedback)
26 May: Target Operating Model and Workforce Redesign
21 Sept: NHS People Plan and The Cupboard
24 Nov: Inclusive Leadership

OUTCOME: The Committee **NOTED** the position.

132/21 **2022 WORKFORCE COMMITTEE DATES**

2022 dates were shared with colleagues.

133/21 **ANY OTHER BUSINESS**

No other business was discussed.

134/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Education Committee
Sickness Absence and Turnover
Vacancy Deep Dive
Enhancements to Wellbeing Package
FTSU Mid-Year Report
BAF – Colleague Engagement
Hot House Topics

135/21 **DATE AND TIME OF NEXT MEETING:**

Tuesday 15 February 2022, 3.00pm – 5.00pm via MS Teams

Karen wished everybody a happy and healthy Christmas and best wishes for 2022.

Calderdale and Huddersfield NHS Charity

Minutes of the Charitable Funds Committee meeting held on Monday 22 November 2021, 9.00am – 10.30am via Microsoft Teams

PRESENT

Philip Lewer (PL)	Chair
Gary Boothby (GB)	Director of Finance
Ellen Armistead (EA)	Director of Nursing/Acting Chief Executive
Richard Hopkin (RH)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Adele Roach (AR)	BAME Representative

IN ATTENDANCE

Emma Kovaleski (EK)	Fundraising Manager/Ops Sub Committee Rep
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Lyn Walsh (LW)	Finance Manager
Katie Booth	CNS Child Development Service
Christopher Button	Lead Cancer Nurse

1. DECLARATION OF INDEPENDENCE

At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. APOLOGIES FOR ABSENCE

Apologies were received from David Birkenhead, Zoe Quarmby and Jo Kitchen.

3. MINUTES OF MEETING HELD ON 23 AUGUST 2021

The minutes of the meeting held on 23 August 2021 were approved as an accurate record.

4. ACTION LOG AND MATTERS ARISING

EK gave an update on the action log and this was NOTED.

EK mentioned that the three actions around a Fundraising Strategy will be covered in a paper to be brought to the next meeting in February 2022.

PW reported that they are developing a few actions, having had some informal meetings with EK and Anna Basford but that the action to include EK at a Reconfiguration meeting is still open and a meeting will be arranged in the new year.

ACTION: EK to bring Fundraising Strategy paper to next meeting. **22.11.21 – 1**.

5. RISK REGISTER - REVIEW

EK presented the Risk Register and its contents were NOTED. This is a live document which is reviewed at each meeting and then updated if necessary.
RH felt that some of the risk ratings were slightly low, in particular the ones around income targets (7421) and unrestricted funds (4063) and it was agreed that EK would review and amend for the next meeting in February 2022. The other risks and scores were approved.

ACTION: EK to review risks around income targets and unrestricted funds. **– 22.11.21 – 2.**

6. Q2 INCOME & EXPENDITURE SUMMARY and KPI UPDATE

EK gave a comprehensive overview of Q2 activities and it was noted that most KPIs had been achieved.
GB brought to the committee's attention that, despite the KPI success, the increased activity via internal fundraising and, in turn, team building and brand awareness, the donated income forecast was reduced to £237k.
PL was happy that this had been aired and the committee agreed that there were mitigating factors such as the delay in the recruitment of the full fundraising team, plus the public now possibly looking at other charities and also its own finances.
It was felt that once the team was embedded, it can move its focus from internal to external fundraising which was essential in order to develop the income line significantly. With the right strategy and staffing moving forward, this drop in income can hopefully be corrected. This will be looked at again in February as part of the Fundraising Strategy paper – see action 1.
The Winter Wishes Internal Campaign was discussed and it was agreed to amend the maximum bid to £500 and cap the overall spending at £10k.

ACTION: EK to set up and publicise Winter Wishes Campaign - **22.11.21 – 3.**

7. ABRAHAM ORMEROD FUND

PL and CH gave a summary of a recent request for funds from a member of Todmorden BC and our reply. CH also gave an overview of A Ormerod funds and it was agreed that PL and GB would meet to make recommendations to the committee at the February meeting around whether to continue with the Todmorden BC meetings, which individuals to deal with in the future and whether to accept single bids.

ACTION: PL/GB to bring a paper re recommendations to the February meeting. **– 22.11.21 – 4.**

8. FRAILTY FUND – REQUEST TO SET UP NEW FUND

EK presented this request and the committee agreed that this new fund could be set up.

ACTION: CH to set up new Frailty Fund and inform the relevant parties **– 22.11.21 – 5.**

9. PREHABILITATION CANCER SERVICE PROPOSAL

Christopher Button presented this bid to support one year's funding for two staff members in this service.

The committee was inclined to support this but asked that he bring the bid back to the February meeting after looking at a possible contribution from other Medical charitable funds, links to the health inequalities strategy, CCG/primary care contribution and identifying and quantifying the benefits.

PL said that if CB felt there was a problem re continuity of staff before February, he could come back and discuss with PL/EA/GB/DB.

ACTION: CB to bring bid back to February meeting. **– 22.11.21 – 6.**

10. RAINBOW CHILD DEVELOPMENT UNIT

Katie Booth (Nurse Manager) gave a comprehensive presentation to support her bid for items to enhance the Rainbow Child Development Service when it moves to its new location in Elland. After discussion around other FSS funds, it was agreed that the committee would support this bid in full but asked that, for future enhancements, they look at FSS funds. It was also mentioned that the children and their families should be involved in the design work and that this would be beneficial for marketing of the Charity.

ACTION: CH to set up approval and progress this expenditure **– 22.11.21 – 7.**

11. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 22 SEPT 2021

The paper is for information only and its contents were NOTED.

12. STAFF LOTTERY COMMITTEE MEMBERSHIP – ratification

The contents were noted and ratified by the committee.

13. ANY OTHER BUSINESS

Defibrillator Boothtown – PL to check what stage the requestor is at with their fundraising for the defibrillator. GB and PL to report back in February 22 with recommendations around AO fund and the charity in general.

ACTION: GB/PL to bring a paper re recommendations to the February meeting. **–** link to action **22.11.21 – 4 above.**

DATE AND TIME OF NEXT MEETING:
Tuesday, 8 February 2022, 10.30 – 12am, via Microsoft Teams