Papers for Information - Meeting of the Council of Governors - 28 January 2021

Organiser Jacqueline Ryden

Documents for Review

b. Updated Register of Council of Governors

1. RECEIPT OF MINUTES FROM BOARD SUB COMMITTEES

a. Quality Committee meetings held on 28.9.20, 26.10.20, 30.12.20

b. Workforce Committee meetings held on 19.10.20, 16.11.20, 9.12.20

c. Charitable Funds Committee meeting held on 25.11.20

d. Audit and Risk Committee meeting held on 21.10.20

e. Finance and Performance Committee Meetings held 2.11.20, 30.11.20, 11.01.21

f. Organ Donation meeting held on 13.1.21

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 28 September 2020

STANDING ITEMS

149/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public-elected Governor
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Maxine Travis **(MT)**	Senior Risk Manager
Lucy Walker **(LW)**	Quality Manager, Calderdale & Huddersfield CCG
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Dr Elizabeth Loney **(EL)**	Associate Medical Director (item 162/20)
Dr Rehan Naseer **(RN)**	Clinical Director for Medical Specialities (item 153/20)
Kimberley Scholes **(KS)**	Business Manager – FSS Division (item 154/20)
Janet Youd **(JY)**	Emergency Nurse Consultant – Corporate (item 155/20)

Doriann Bailey was introduced to the meeting, as the new Assistant Director of Patient Safety.

150/20 APOLOGIES

Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Andrea Dauris **(AD)**	Associate Director of Nursing, Quality and Safety
Lindsay Rudge **(LR)**	Deputy Director of Nursing

151/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

152/20 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Wednesday, 2 September 2020 were approved as a correct record.

The action log can be found at the end of the minutes.

AD HOC REPORTS

153/20 INVITED SERVICE REVIEW - RESPIRATORY

Dr Rehan Naseer (Clinical Director for Medical Specialities) was in attendance to present the results from an invited service review undertaken by the Royal College of Physicians in March 2019, following never events which related to oxygen outlets.

The action plan, as detailed at appendix B, was generated following the review.

All actions are now complete or on track, with the exception of action 10 which was previously completed - t*he Trust should urgently consider replacing the locum consultant with a substantive consultant and prioritise recruitment in order to have eight substantive respiratory consultants and a seven-day service*. A Consultant had been appointed; however, they are due to leave the Trust and a plan to appoint by February 2021 is now in place.

RW asked if any projects had a focus on improving patient experience. RN reported that the projects related to COVID, are to develop a COVID follow-up clinic and COVID information leaflet with access to national websites to try to improve patient experience. Patient feedback is also discussed in the quality meetings, as well as any feedback from patient complaints, etc and how to improve patient care

CP stated that the actions were put in place following a never event, then a further two never events prompted a detailed review and part of this invited service review. It was asked if any retests or challenges around staff skills, training and awareness have taken place recently to be assured that this could not happen again. RN responded that in terms of staff skills and awareness and training, those are now part of the current training carried out regarding oxygen and non-invasive ventilation. In terms of physically checking that the ports remain closed off, this will need to be double-checked.

AMc asked what was found following the equality impact assessment which was stated as complete on the front of the report. RN stated that this section was completed by a colleague and agreed to follow-up on the outcome.

DBy had an interest in the lessons learnt and wanted to understand how they were shared across teams and if there were any plans for further audits to assess the embedding of those lessons learnt. RN stated that the report was shared within the nursing, consultant and quality meetings, as well as the newsletter on shared learning within the division. In terms of an audit to understand the learning, this has not been carried out, however, an audit can be completed to ensure that lessons have been understood. DBy asked for a copy of the results once completed.

The Chair thanked RN for reporting a positive, detailed report.

OUTCOME: The Quality Committee received and noted the action plan.

154/20 OUTPATIENT IMPROVEMENT PLAN

Kimberley Scholes (Business Manager for FSS division) was in attendance to provide an update on progress with the outpatient action plan as at appendix C.

Since work on the action plan began, there have been significant changes in outpatients due to COVID-19. All actions, both the open and closed were reviewed, with no closed actions needing to be reopened, however, there have been significant changes in the actions still outstanding.

In relation to staffing, one area of the action plan was to review staffing from a nursing point of view, knowing that over time, there would be more virtual clinics, e.g. telephone or video; however, due to COVID, this has now changed completely in terms of virtual capacity. In relation to nursing, this has completely changed due to colleagues being redeployed to support the segregated emergency departments and wards, and this is an ongoing process. Another area of staffing was to have a model for booking, and there is now an outpatient booking service in the appointment centre. This is currently ongoing as a result of COVID due to workload changes, cancellations, re-bookings, etc, and a third-party company – Meridian - is currently in the Trust working with specialties.

Another change has been around capacity. There are increased waiting lists for both new patients and follow-up patients, therefore mitigations have been increased with work around prioritising both new and follow-up patients, and ensuring the capacity is used not just for

patients waiting the longest, but also for patients who are clinically most urgent and in need of being seen. Clinicians have been working closely with GPs and getting their input to review referrals, ensuring they are appropriate; signposting patients to different routes of care where necessary, treating patients in different ways, and different ways of working such as clinical assessment clinics. Work is ongoing with the transformation team on patient-initiated follow-up (PIFU), which involves patient input on when they need to be seen.

KS reported that current concerns are around capacity and data quality issues.

AMcC queried the term '*reasonable assurance'* in the report and asked whether the update was reflective of the assurance rating. Another question was whether there was any understanding of the impact of the equality impact assessment. KS reported that as part of the restart, each specialty was expected to complete the equality impact assessment via the Incident Management Team (IMT) meeting.

In relation to the original 50 recommendations presented on the action plan to the Quality Committee in February 2020, the Chair asked if the third-party company Meridian were also reviewing these actions. KS confirmed that the company were not reviewing the actions, but reviewing issues from a productivity point of view, and how to best utilise capacity, booking teams and streamlining. The Chair asked for the status of the action plan, and KS agreed to follow this up and report back.

KH stated that this report was a summary of the action plan that was previously presented and had a question around access issues. The report's summary stated, *'the pause due to COVID-19 will provide an opportunity during recovery to transform the service going forward'.* It was asked if the plans could be seen as it would be useful to see the progress of the transformation. It was asked that further detail is provided in the report, which would then improve the reasonable assurance rating.

ACTION: A more detailed report and the status of the original action plan was requested

155/20 MENTAL HEALTH POLICY

Janet Youd (Emergency Nurse Consultant) was in attendance to present the Policy for the Care of Patients with Mental Health Disorders as detailed at appendix D1 and D2.

The key issues are that it links to a joint protocol with partners at South West Yorkshire Partnership NHS Foundation Trust around administration of the paperwork to ensure that the Mental Health Act when applied at CHFT, is within the legal framework. The Policy is about promoting safe care and dignity for patients who present with mental health disorders, and within the Policy, it links to separate guidance for specialist areas, therefore the Policy for Children and Young People will have separate legislation regarding the Children's Act. There are also different clinical guidelines in different areas, therefore a risk assessment will be carried out if the guidance is updated and the Policy will remain as it.

ES stated that some work is being done with admission consultants and queried about consent with checking patient's clothes and bags for medication that they can self-harm with. The Policy mentions consent for checking bags and clothes for objects that can be used for self-harm, however, it was asked whether insulin pens, tablets and illicit drugs could be added to the Policy if possible. JY agreed to this and stated that at the next Mental Health Strategy Group, a separate document around guidance for searching will be proposed.

RW raised the point about referring to other duties that are applicable when reviewing Policies and practices. It was asked that we ensure that reference is made to our continuous quality improvement duty and also to patient experience when reviewing Policies. JY agreed with the comment and reported that this is the first draft of the Policy and that patient dignity is at the heart of this which is concurrent with the World Health Organisation recommendations around mental health, also that one of the CQC lines of enquiry around mental health is on user

feedback, and links with the NCEPOD 'Treat as One' report from 2017, which centres around patient experience.

The Chair thanked JY on the amount of work undertaken to get the Policy to where it is and would support ongoing the review and development of new Policies to include reference to continuous quality improvement and patient experience.

The Chair also asked JY of any likely challenges regarding implementation of the Policy. JY stated that the big drivers will be around staff awareness, staff training specifically about understanding mental health issues and ensuring that that robust, timely, user feedback is gathered. It will also need to link with the complaint's procedure, risk management and how the risks are mitigated in a dignified way for patients. It will require a culture change going forward.

OUTCOME: The Quality Committee noted the Policy and the further work to be undertaken before approval.

156/20 SERIOUS INCIDENT DEEP DIVE

To be deferred – see action log.

SAFE

157/20 QUALITY PRIORITY – NOSOCOMIAL SPREAD INCLUDING INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK ACTION PLAN

To be deferred – see action log.

158/20 MEDICATION SAFETY AND COMPLIANCE GROUP UPDATE

ES presented an overview of medication safety issues reported at the Medication Safety and Compliance Group in July and August 2020, as detailed at appendix G.

There was an increase in medication incidents in August 2020, however, there was also a decrease in harm, which shows a healthy reporting culture. The majority of the incidents were administration and prescribing issues, and four incidents recorded in August 2020 which resulted in moderate patent harm were detailed in the report and are currently being investigated. The Controlled Drugs sub-group meeting was cancelled due to apologies and lack of divisional representation, and a request was made for attendance at the group to ensure quoracy and consistent communication to divisions.

ES reported that a paper was submitted to the Weekly Executive Board and the Health and Safety Committee regarding the concerns and complexities with medical gases. One issue raised was testing of colleagues who worked in areas with Entonox and Nitrous Oxide. There are still areas that have not completed risk assessments and follow-ups are being made to the areas that still require them carried out. Work is ongoing with Occupational Health to embed a Standard Operating Procedure for ensuring tests are carried out on a yearly basis.

The Chair raised concerns with the medical gas issues and the three areas which have not yet nominated a lead for risk assessments and asked who the most accountable person would be to get this resolved. ES stated that the new Health and Safety Officer recently in post will be assisted by people already involved in this to resolve.

DBy had a query regarding the medication incidents and prescriber involvement and asked if there was any correlation with prescriber issues and the pharmacy preparation and dispensing. ES reported that a piece of work is ongoing to look at handwritten prescriptions in outpatients to see what can be done to move that forward. It was also stated that there are issues where the outpatient dispensing service are struggling to read handwritten prescriptions.

KH reported concern on the inconsistency with medication safe storage as this has been reported on many occasions. Divisional representation at the Controlled Drugs subgroup was also mentioned by both KH and the Chair, stating that attendance is very important in order to support the work ongoing.

The Chair noted that it was very useful to see the medicines management newsletters, which included high-quality and important information, and asked if there was any evidence that colleagues are reading and applying the information within the newsletters. ES reported that they are used and read out at handover meetings but is not sure on how often this happens as it is not tested, but hopes that it happens more in areas where specific incidents have occurred.

OUTCOME: The Quality Committee received and noted the report.

RESPONSIVE

159/20 QUALITY PRIORITY – IMPROVE RESOURCES FOR DISTRESSED RELATIVES / BREAKING BAD NEWS RELATING TO END OF LIFE CARE

To be deferred to the next meeting.

160/20 QUALITY PRIORITY – END OF LIFE CARE

CP provided a verbal update on this quality priority around the provision of compassionate and patient-centred end of life care which is seen as a high priority for the Trust.

In achieving this priority, the needs of both the patient and their families and carers does not vary in quality because of an individual's characteristics, by ensuring care providing is individualised, timely and relevant.

This is being aligned with work done in the community, the hospital and the hospice with the systems resilience group priorities, which is a wider piece of end of life care. The three priorities are:

- Identification of people in the last 12 months of life, and high-quality communication with them in order to deliver excellent care;
- Co-ordinated, timely and equitable access to good care
- Exemplary care in the last hours and days of life

A work together, get results (WTGR) session was set up in February 2020 where work was undertaken with specialist palliative care teams with representatives from the hospice and the community. This resulted in three priorities for the team which align with the three mentioned above:

- Robust education to enable an early and end of lift conversation
- Seven day working across the system resulting in an outstanding CQC rating
- A mixed-skill team which mirrors caseload

Following the initial surge of COVID-19 and the output of the first WTGR session, three workstreams were agreed, which will be overseen by the Steering Group over the next 12-18 months:

- Advanced care planning and the electronic palliative care coordination system (EPaCCS)
- Improving training and education for end of life care
- Seven-day speciality palliative care input for inpatients and community, to include the specialist end of life care beds that were implemented during COVID

Workstream leads have now been assigned, and a second WTGR session took place last Thursday. It was also mentioned that the Chief Nurse is keen that getting it right first time (GIRFT) methodology is utilised in palliative care.

The Chair thanked CP for the update and requested a further update before the end of the financial year.

161/20 INTEGRATED PERFORMANCE REPORT

CP reported on appendix J and highlighted that the Summary Hospital-level Mortality Indicator (SHMI) has increased to over 100 for the fist time in over 12 months, and will be re-based during COVID, along with Hospital Standardised Mortality Ratios (HSMR). Healthcare Evaluation Data (HED) who publish the data, will remove COVID deaths from the statistics going forward, however, that should not mask the fact that prior to COVID from November 2019 to March 2020, the Trust's mortality position had worsened.

In association with that, there have been three red SHMI alerts around gastrointestinal bleeding, other gastrointestinal issues and cardiovascular malignant arrythmias particularly ventricular fibrillation, therefore mortality reviews are being conducted on those outliers to understand what might be going on. Five amber alerts were also received which show a trend towards potential issues in those areas.

There is some concern, however, it is not known what is causing the upward trend. The previous trend around 18 months ago was related to palliative care coding issues and depth of coding around discharges, making it an artificial inflation of mortality. Unfortunately, none of those apply this time and there may be a genuine upstroke in mortality. A paper is being submitted to the Mortality Surveillance Group in October.

CP also mentioned the clinical prioritisation work which relates to the pause in outpatients during the first COVID surge. Consultants were carrying out a review of patients with a delay of 12 weeks or more, and placing them in one of five categories to ensure they were prioritised with no harm results:

Category 1 - Required to be seen urgently within two weeks
Category 2 - Required to be seen urgently within six weeks
Category 3 - Required to be seen urgently within 12 weeks
Category 4 - Advice to the GP and can potentially be delayed a certain number of months
Category 5 - Discharge

This piece of work is ongoing and there are issues on how this is being recorded as it is done on a spreadsheet which does not link directly to the electronic patient record (EPR) and is designed to capture any risk or potential harm as part of those delays.

A buddy system has also been developed, whereby a non-clinical person becomes the designated contact for patients. Once the patient's outpatient review has been established as delayed, the non-clinical person contacts them to explain this and then becomes their future contact.

RW queried what the key lines of enquiry being adopted in the mortality specific review were, and CP welcomed a further discussion on this.

EFFECTIVE

162/20 CLINCIAL AUDIT UPDATE

Dr Elizabeth Loney (Associate Medical Director) was in attendance to present the clinical audit programme for 2020 / 2021 as detailed at appendix K.

In the last six months, there has been a significant change in clinical audit and the mandated clinical governance half-day meetings, which were cancelled, resulting in audits not being able to be presented, however, some groups continued to have non-mandated clinical governance meetings, particularly in Obstetrics, Gynaecology and Paediatrics, and in September 2020, the medical division and general surgery held their governance meeting. A paper was submitted to the Incident Management Team (IMT) regarding the restart of mandated governance meetings hopefully from November 2020.

With regard to audit submissions, there are national audits to which the Trust is mandated to or need to submit data to, and most of these continued during COVID in some form. Many of the audits in the surgical division continued at the discretion of the data inputters, some audits were placed on hold, for example the stroke audit and diabetes audits, and now starting to begin again.

Another piece of work undertaken was the implementation of the national data opt-out. The regulation was due to come into force in March 2020, was then moved to October 2020, and has now been deferred to the end of March 2021. Patients can opt-out of having their data shared for non-treatment purposes, by signing the opt-out which is on a national database. This database is not held by the Trust; therefore, the clinical audit team contacted each of the national data organisations to ask them whether the data submitted falls under the national opt-out regulation or not. This has been a huge piece of work for the clinical audit team and thanks were conveyed to them for carrying that out. Further work has taken place with the information governance team and the health informatics service to produce a standard operating procedure for people to submit their data to the national spine to check whether patients have opted out. One way to work around this, is to have all patients consented to have their data shared as part of research and training at the time of their procedure. This is currently work in progress and can apply to other areas of patient care.

External audits were put on hold and now restarting, and an audit of clinical audit by Audit Yorkshire is due to take place next month.

Clinical Audit Awareness Week is taking place in November 2020, and the Trust would like to run an audit competition to highlight the excellent work taking place across the organisation and to allow colleagues to present their audits at an hour's session over lunchtime, to everyone in the Trust.

CP confirmed that the governance half-days will recommence from November 2020 and colleagues will be able to cancel clinical elective commitments as required, to attend the requisite number of governance sessions per year.

MT stated that within serious incident and divisional orange investigations, the findings from those investigations and output are being triangulated with clinical audits and feeding into various task and finish working groups.

OUTCOME: The Quality Committee received and noted the report.

CARING

163/20 ANNUAL COMPLAINTS REPORT

RW presented the 'Making complaints count' annual report at appendix L, which will form part of an appendix following the complaints review which is currently ongoing.

The report highlights the pause on NHS complaints during COVID, however, an improved position in relation to complaints closed on time was not noted.

A review is currently underway which will be reported to the Executive Board in November 2020, and any comments were welcomed. It was proposed that the draft report is initially

submitted at the Quality Committee with an opportunity for detailed discussion during protected time at the next meeting.

DBy asked whether the review will be revising the team structure to dedicate a lead on this, as this has been an issue for the organisation, and improvements need to be demonstrated to the CQC that the staffing and infrastructure are in place to take this forward. RW stated that the intention is to carry out an intensive review, looking at the governance and reporting structure, the team and their workload and opportunities to streamline.

WELL-LED

164/20 PROPOSED APPROACH FOR DEEP DIVES WITHIN THE BOARD ASSURANCE FRAMEWORK

RW presented a proposed approach for deep dives within the Board Assurance Framework, at appendix M.

A process is needed to understand risks and risk registers, by carrying out a deep dive to ensure they are applicable and meaningful going forward. The key questions to be asked were set out in the proposal, and RW asked if AMcC would oversee the process. There are five risks where the Quality Committee will lead and two risks where the Workforce Committee will lead with a supporting role from the Quality Committee.

AMcC reported continued support with the population of the Board Assurance Framework into Boards and Committees, and historically, the risks sit with the risk owner only, and the purpose of this process is to use the Committees to review the risks and provide assurance about the risks to the Board. The Board Assurance Framework reports to the Board of Directors and the Audit and Risk Committee three times a year, so it is not as regular as the risks and are more strategic and long-term. AMcC stated that the planning of the review of each risk and challenges to the risks would need to be done at the meeting and would need Committee ownership.

The Chair stated that the plan from the next Quality Committee, is to review a different Board Assurance Framework risk, using the proposed framework for the deep dives. JE reported that the Workforce Committee regularly review and interrogate their Board Assurance Framework risks.

AMcC also asked that the Committee consider any new risks for the Board Assurance Framework based on strategic objectives.

165/20 DUTY OF CANDOUR INTERNAL AUDIT REPORT

MT reported on the internal audit results of the second stage of duty of candour as detailed at appendix N.

The second stage of duty of candour takes place at the end of the investigation for a divisional orange investigation or a serious incident investigation, and ensures that the legal obligation in terms of duty of candour were delivered within the set timescale of 10 days, and whether the content of the letter was sufficient to deliver that.

The audit provided significant assurance and made a number of minor and moderate recommendations to further improve that assurance. These were detailed in the report.

Discussion on the definitions of first and second stage duty of candour took place, with MT describing the processes, and DBy agreed to follow this up with MT outside of the meeting.

166/20 QUALITY COMMITTEE ACTION PLAN

The Chair reported on the Committee's self-evaluation which was completed earlier this year, resulting in the action plan at appendix O describing the Committee's actions to improve effectiveness.

One of the concerns was receiving papers in on time and it was asked if anything needs to be done differently to help people who are submitting reports.

KH commented that the Committee has a forward planned schedule, and it is assumed that authors are made aware of upcoming meetings and given a prompt for their reports. MA confirmed the process; however, some reports are last-minute, which results in papers not being read in detail in order for a robust conversation at the meeting.

DBy stated that the culture of tabling reports just before a meeting needs to be eradicated and that report authors need to prioritise reports as it impacts on the Committee being able to move critical agenda items forward.

RW specified drawing a line under the submission date and if a paper has not been provided, then it needs to be removed from the agenda, and holding each other to account.

The Chair was pleased of the support of the Committee and welcomed any further comments on the action plan.

POST MEETING REVIEW

167/20 MATTERS TO REPORT TO THE BOARD OF DIRECTORS

- Update on the invited service review for respiratory with all actions completed or in progress
- Update on the Mental Health Policy and further work needed before approval
- Medication Safety Compliance Group concerns with the medical gases and non-attendance at the Controlled Drug sub-group from divisions
- The increased Summary Hospital-level Mortality Indicator in over 12 months from the integrated performance report.
- Received the Annual Complaints report

168/20 REVIEW OF MEETING

What went well….

- The reports which were submitted were succinct, focussed and allowed for discussion
- Members introducing themselves before reporting
- Scrutiny of reports with positive challenge by members
- Had constructive debate and challenge

What could be better……

- Getting the papers circulated on time to achieve standard of circulating papers 7 days in advance.

169/20 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

170/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix P which will be refreshed in light of developments of the governance structure, and the agendas will include the quality priorities and the Board Assurance Framework deeps dives on a monthly basis.

NEXT MEETING

Monday, 26 October 2020 at 3:00 – 5:00 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 28 SEPTEMBER 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS				
2.9.20 (132/20)	**QUALITY PRIORITY - MEDICAL DEVICES**	Divisions	**Action 2.9.20:** Medical devices training and maintenance to be added as a risk on divisional risk registers **Update September 2020: MA to check with all divisions that this is on risk registers.**	**Reminder sent on 19 October**
2.9.20 (133/20)	**QUALITY PRIORITY – FALLS RESULTING IN HARM**	Helen Hodgson	**Action 2.9.20: HH to take comments back to the Falls Collaborative to reconsider the 10% reduction target and to provide further assurance to the Quality Committee** **Action 2.9.20: The equality impact assessment to be completed.** **Action 2.9.20: Benchmarking data from other Trusts to be added to the monthly falls dashboard.**	**Reminders sent on 1 October and 20 October – no response received as yet**
5.2.20 (21/20)	**OUTPATIENTS IMPROVEMENT PLAN**	Kimberley Scholes	**Action 5.2.20:** Progress on actions from the outpatient's improvement plan to be provided in April 2020. **Update June 2020:** Awaiting steer from Executive Director of Nursing due to a number of amber/red actions which need clarity in the context of COVID-19 **Action 28.9.20: A more detailed report and the status of the original action plan was requested**	**Reminder sent on 19 October – no response received as yet.**
29.6.20 (103/20)	**INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK**	David Birkenhead	It was stated that in the future, it would be good to get an update on how the recommendations have been implemented, and DB agreed that an action plan with an assurance statement against the 10 standards and any new guidance that has been issued, can be brought back to the Committee. **Action 29.6.20**: Action plan to be brought back to the Committee at a later date. **Update August:** Progress report will be made available for 28 September 2020 meeting **Update Sept: To be deferred**	**Due on next agenda on 29 October 2020**
FORTHCOMING ACTIONS				
3.8.20 (121/20)	**QUALITY COMMITTEE ANNUAL REPORT ACTION PLAN**	Chair	**Action 3.8.20: An action plan will be submitted to the Committee once the results have been reviewed.**	**DUE Monday, 30 November 2020**
2.9.20 (140/20)	**COMMUNITY DIVISION REPORT**	Community division	**Action 2.9.20: Feedback on the development of non-concordance in relation to pressure ulcers to be provided in the next quarterly report.**	**DUE Monday, 30 November 2020**
1.7.19 (120/19) 2.3.20 (41/20)	**SERIOUS INCIDENTS DEEP DIVE**	Maxine Travis	**Action 1.7.19**: OW to be invited to a future meeting to present next steps. **Update 29.7.19:** Work is ongoing to review systems and processes, with an action plan being pulled together. **Update 30.9.19:** A three-month update was provided – see item 176/19 **Action 30.9.19**: Further update to be provided in six months' time, and maybe earlier if improvement and sustained change is not noted. **Update 2.3.20:** Following discussion on target timescales of between 25 to 40 working days for responding to complaints, it was queried why the same timescale cannot be delivered for serious incidents. **Action 2.3.20: Deep dive into serious incidents to take place.** **Update September: MT reported that a conversation with the new Assistant Director for Patient Safety will need to take place regarding plans going forward with serious incident investigation capacity. This item to be deferred.**	**TBC**
CLOSED ACTIONS				
2.9.20 (132/20)	**QUALITY PRIORITY - MEDICAL DEVICES**	Divisions	**Action 2.9.20: Medical devices training and maintenance to be added to PSQB agendas as a regular item** **Update September 2020: MA has now added medical device training to all Patient Safety and Quality Board workplans - COMPLETED**	**CLOSED Monday, 28 Sept 2020**
2.9.20 (138/20)	**QUALITY AND SAFETY STRATEGY**	Ellen Armistead	**Action 2.9.20: Any comments on the strategy, to be forwarded to EA outside of the meeting.** **Update September: This has now been submitted to the Board and cascaded throughout the organisation shortly.**	**CLOSED Monday, 28 Sept 2020**
2.9.20 (139/20)	**INTEGRATED PERFORMANCE REPORT**	Denise Sterling	**Action 2.9.20:** DS to follow up concern with the return to work interviews and two areas of recruitment that are still not achieving the target, with the Workforce Committee. **Update September 2020: JE confirmed that the action has now been followed up. JE also assured the Quality Committee that the Workforce Committee reviews the whole spread of the workforce domain targets, particularly those concerning sickness absence and recruitment. The Workforce Committee is aware of the variance in compliance on the recruitment targets as well as the ongoing difficulties with the return to work interviews and will be reviewing them as business as usual.**	**CLOSED Monday, 28 Sept 2020**
2.9.20 (135/20)	**MEDICATION SAFETY AND COMPLIANCE REPORT**	Anita Hill	**Action 2.9.20:** AH to find out the timescales for when departmental assessments in relation to exposure tests for nitrous oxide and Entonox need to take place. **Update October: See item 158/20. These must be completed annually but as no areas have had these done, all of them need doing asap**	**CLOSED Monday, 28 Sept 2020**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 26 October 2020

STANDING ITEMS

171/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Dr David Birkenhead **(DB)**	Medical Director
Andrea Dauris **(AD)**	Associate Director of Nursing - Corporate
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public-elected Governor
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Maxine Travis **(MT)**	Senior Risk Manager
Lucy Walker **(LW)**	Quality Manager, Calderdale & Huddersfield CCG
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Joyce Ayre **(JA)**	Head of Midwifery (item 175/20)
Christopher Button **(CB)**	Lead Cancer Nurse (item 183/20)
Salome Kadelera **(SK)**	Student Nurse (observing)
Philip Lewer **(PL)**	Chairman (observing)
Dr Julie O'Riordan **(JOR)**	Divisional Director – FSS Division (item 175/20)

172/20 APOLOGIES

No apologies were received.

173/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

174/20 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Monday, 28 September 2020 were approved as a correct record, with the exception that the penultimate paragraph of section 166/20 reads:

*'RW specified drawing a line under the submission date and if a paper has not been provided, then it needs to be removed from the agenda, and holding each other **to** account.'*

The action log can be found at the end of the minutes.

AD HOC REPORTS

175/20 MATERNITY SERVICE SAFE IMPROVEMENT PLAN

Dr Julie O'Riordan (Divisional Director for FSS) and Joyce Ayre (Head of Midwifery) were in attendance to present appendix B on the maternity service's safe improvement plan, and the key points were summarised as detailed in the report.

In relation to the action plans, it was noted that the Healthcare Safety Investigation Branch (HSIB) investigation time frames were lengthy at the time, which meant that reports were received some time later after the investigation, hence the one outstanding action plan with two delayed actions. These were due to be signed off next month at the FSS (Families and Specialist Services) division's orange panel meeting.

Further detail was provided on two pieces of quality improvement work undertaken; the cumulative risk assessment; a review undertaken in response to a number of clinical incidents involving the Maternity Assessment Centre (MAC) over the previous 12-18 months; cardiotocography (CTG) interpretation work, and CHFT being highlighted by the Perinatal Institute for being one of the top 10 maternity units in the country for detecting small for date babies during April and June 2020.

Key messages going forward included leadership training needed for key staff and safety culture work reports being out of date due to COVID-19. Actions taken for these included labour ward co-ordinators being encouraged to undertake leadership training via the CHFT cupboard; and suitable safety culture tools being identified to refresh the safety culture work.

Next steps include auditing the improvement work and changes made to practice; continuing the cardiotocography (CTG) interpretation training; utilising the NHS England / Improvement maternity safety support programme self-assessment tool and base an updated maternity SAFE improvement plan on the findings.

A detailed service improvement plan was available in the report.

EA reported that following the last meeting, the Trust were contacted by HSIB who were very complimentary on the level of engagement within the organisation and were positive on the improvements that have been put in place.

KH asked whether the actions on the improvement plan labelled '*will progress to timescale*' had passed their deadline date, or whether the deadline dates should be updated. JA reported that those actions have now been carried forward and are still being developed, however, the RAG rating will be updated to reflect the ongoing progress.

In relation to support being needed with a suitable safety culture tool, DS asked whether any existing tools were available, or whether one will need to be developed. JA stated that some work had been done previously with NHS Improvement using their tool, however, the results took some time to be returned, therefore further tools which can be used in a timelier manner, are being sought.

JOR reported that the team, led by JA, responded positively to the HSIB investigations and the review of safety within maternity, and had a positive attitude to it. JOR thanked JA for her leadership and on the positive feedback from HSIB, which reflects the team's fantastic engagement.

DS asked if there were any plans to get the training which has slipped due to COVID-19, back to where they should be. JA stated that funding for the leadership training was one of the issues, however, co-ordinators have been encouraged to undertake the in-house leadership training. The other issue involved the competency assessment for fundal height measurement, which is currently underway. JA also noted that CHFT's Practical Obstetric

Multi-Professional Training (PROMPT) continued throughout the COVID-19 period, whereas other Trusts did not.

DS thanked JA and JOR for the detailed report.

OUTCOME: The Quality Committee approved and supported the recommendations from the report.

176/20 LEARNING FROM DEATH REPORT

Dr Cornelle Parker presented the learning from death report at appendix C, highlighting the mortality review process during quarters 1 and 2, and also noting that the annual learning from death report, together with an analysis of COVID-19 deaths was submitted to the Board of Directors in July 2020.

During quarter 1 (April to June 2020), there were 449 adult in-patient deaths, and 325 in quarter 2 (July to September 2020). It was noted that quarter 1 was heavily impacted by COVID-19. Of the 774 adult in-patient deaths over both quarters, 163 (21%) were reviewed using the initial screening review (ISR) tool. This falls short of the 50% target for mortality reviews, due to the process being suspended as part of the COVID-19 response, and clinicians being needed to increase capacity for clinical activity.

A total of 72 detailed structured judgement reviews (SJRs) were requested over both quarters, and 66 completed. Unlike the ISRs, SJRs were not suspended during COVID-19. Most of the reviews fell into the 'adequate care', 'good care' or 'very good care' categories. 12 reviews scored 'poor', which then trigger further investigation by divisions.

The learning themes from the investigations were identified in the report, as well as good practice, which is being shared with individuals mentioned in the SJRs care record as demonstrating good care.

The recommendations for 2020/21 are for 50% of all in-patient deaths to be reviewed by June 2021; Consideration of how SJR themes can be used to support improvement projects aligned to the Trust quality priorities; and to work alongside the new Medical Examiner team and align the learning from death processes.

RW asked if there was any further understanding of how many of the 12 'poor care' scored reviews ended up as a complaint. CP reported that of the 12, one was investigated as a complaint, and the next step will be to establish what changes have taken place within the division in response to learning.

OUTCOME: The Quality Committee approved and supported the recommendations from the report.

CARING

177/20 MAKING COMPLAINTS COUNT

Rachel White (Assistant Director of Patient Experience) presented appendix D, the 'Making complaints count bundle', which consisted of four key papers: a service review, an annual report, a bi-monthly report and an internal audit report.

The Committee's attention was drawn to paper one - the service review, and reference made to paper four - the internal audit report. Due to the business continuity and staffing risks highlighted throughout all four papers, it was stated that the scoring of the internal audit is likely to the downgraded to limited assurance.

Following a brief summary, RW welcomed discussion from the Committee.

AD noted the very comprehensive recommendations which reflected the reality of the scoping carried out.

KH also noted the comprehensive report and concern regarding staffing and resource levels. RW reported that since the report was written, an interim head of complaints will be in place until the post is recruited to, with the caveat that funding is available, however, it is critical to success that a strong leader heads the service. KH also queried if CHFT were learning from any other Trusts complaints processes. RW stated that the way complaints are viewed in the organisation needs to be reframed, and at this moment in time, conversations are still to be had with executive teams regarding the resource and reframe implication.

EA stated that one of the recommendations needs to make clearer reference to the 'time to care' strategy. Whilst it may be a nursing and midwifery strategy, it has implications for this and should be referenced. EA also stated that another area which can be strengthened is the cultural shift, and that accountability and responsibility for this needs to sit within the divisions.

MT stated that the 'Head of Incidents' in the project team should be reflected as 'Senior Risk Manager'.

DS noted the very comprehensive report and commented that reference made in the recommendations that the development plan will take 1-3 years, needs to clearly state that this is due to a culture change and shift.

RW also drew the Committee's attention to the fact that equality monitoring data was not previously recorded on Datix, however, amendments have been made in order for reporting against three (age, gender, ethnicity) of the nine protected characteristics to be enabled going forward. Thematic analysis against the characteristics can be made, which will provide an extra level of intelligence.

RW thanked everyone who contributed their time, energy and sharing their views into this report, and agreed to make further clarifications and amendments to the report and to clearly articulate the difference between the cultural aspects and process improvements.

The amended paper will be submitted to the Weekly Executive Board (WEB) in November, and it was agreed that an updated position statement following discussion at WEB will be resubmitted to the Quality Committee, prior to submission to the Board of Directors.

ACTION: Following discussion at WEB, a position statement will be resubmitted

178/20 PATIENT EXPERIENCE AND CARING GROUP

Rachel White (Assistant Director of Patient Experience) presented appendix E, highlighting issues from the Patient Experience and Caring Group meetings in August and September 2020. These included that the Friends and Family Test (FFT) reporting will commence from December 2020; several projects which were commissioned by the Group in response to lower scoring questions from the 2019 survey; an update on the delivery of the dementia strategy; a review of the annual programme for transforming patient and carer participation and experience; developing a readers' panel; divisional reports which focus on the impact that COVID-19 has had on patient experience, and the 'making complaints count' bundle as discussed at item 177/20.

As part of the complaints review process and the annual programme of work, it was found that previous equality impact assessments were not able to be located, therefore an overarching robust equality impact assessment is to be undertaken to inform the patient and carer experience transformation programme going forward. This will include a better understanding of the needs of local communities utilising existing demographic and health inequalities data.

DBy commented that the equality impact assessment is a challenging piece of work, and that individuals may not be aware of the expectations or relevance of it, and suggested that there

may be a requirement for some training or updates for authors of reports to have more knowledge on what is required in relation to an equality impact assessment.

KH also noted that equality impact assessments are vital to help understand why some people react the way they do and how we can then respond appropriately. It was asked if there was anything centrally available on how to undertake an equality impact assessment. EA stated that a process is available, which may need to be reviewed and support being available for individuals to complete. RW agreed that this is required and is due to undertake this piece of work.

DS noted the good examples of 'going the extra mile' within the report which were encouraging and highlighted the elderly patient who did not have access to contactless payment and was supported by a catering colleague with a meal and a drink. It was asked if this could be an issue for other patients. Regarding individuals who may be in need of access to a meal and a drink following a long wait, RW suggested that there would be some opportunity for this to be part of the compassion aspects of the nursing and midwifery strategy.

OUTCOME: The Quality Committee received and noted the report.

SAFE

179/20 HIGH LEVEL RISK REGISTER

Maxine Travis (Senior Risk Manager) presented appendix F highlighting the high-level risk register as at 5 October 2020, which was previously approved at the Risk Group in August and September and submitted to the October Board of Directors.

The report highlights key changes to the high-level risk register. The six top risks scoring 20 and above remain the same as last quarter:

7454 (20): Radiology Staffing Risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7689 (20): Waiting for diagnostics, operations and outpatients (COVID)
7683 (20): Lack of isolation capacity (COVID)

There were no new risks, no risks with an increased score, no closed risks and two reduced risks, as detailed in the report.

MT noted that the Risk Group was re-established in August 2020 following a period where the meetings were stood down due to the pandemic. There has been a review of the terms of reference to focus on the scrutiny and challenge of high-level risks. The remit for compliance will be taken up by the CQC Response Group and the revised terms of references will be submitted to the relevant Committees / Boards for ratification.

The Risk Group will also carry out a monthly deep-dive on either a high-level risk or a long-standing risk on the trustwide risk register, in order for all divisions to discuss and understand what the barriers are to the risk mitigation, what treatment plans are in place and to review the risk scoring.

EA commented that the Risk Group's terms of reference clearly state that risks should not be on risks registers for a long period of time, and that all divisions have been tasked with reviewing all of their risks.

DS noted that several risks on the register were showing a last update from several months ago, and this may need reviewing.

OUTCOME: The Quality Committee received and noted the report.

EFFECTIVE

180/20 QUALITY PRIORITY - IMPROVE STAFF HANDOVERS TO ENSURE THEY ROUTINELY REFER TO THE PSYCHOLOGICAL AND EMOTIONAL NEEDS OF PATIENTS, AS WELL AS THEIR RELATIVES / CARERS

Lindsay Rudge (Deputy Director of Nursing) presented appendix G, updating on the above quality priority.

The Acute Floors identified an increase in patients who were staying longer and had complex needs, therefore a risk assessment tool was put in place and trialled, which was holistic, patient-centred and worked with stakeholders. A presentation on the work carried out was also available as part of the report. The risk assessment tool is now on the electronic patient record (EPR) for other ward areas to access and will be audited. The results will be reviewed at the mental health operational group.

The Community division have also been carrying out work on early supported discharge for stroke patients and psychological therapies as part of their weekly review. A psychologist attends their weekly multi-disciplinary team meeting, so there is holistic support in the early supported discharge in Community. Some work is also ongoing in complex neurology, in which they are assessing mood and signposting into services. The re-ablement service in Community are also focusing on patient-centred goals and ensuring that they risk assess and are alert to social isolation in the Community.

KH commented on the pilot and asked if this linked into the mental health strategy through the operational group. LR confirmed that it does link to the mental health strategy and is also part of the 'treat as one' NCEPOD (National Confidential Enquiry into Patient Outcome and Death) recommendation, on ensuring that we are not only looking at the physical presentation of patients, but also looking at patients who may or may not present with mental health as their primary reason for attending hospital.

DS asked if the tool is now available for use, and if there was any additional information to for those who may not have been involved in the initial development. LR stated that a briefing took place at a weekly nursing leadership session on where the tool is located and how to complete it, which generated a lot of interest. The HRI site have started to use the tool, however, a learning package may need to be compiled to support its wider roll-out.

OUTCOME: The Quality Committee received and noted the report.

181/20 MEDICAL EXAMINER UPDATE

Dr Cornelle Parker (Deputy Medical Director) provided a verbal six-month update.

Appointments to the team were delayed due to COVID-19, however, all vacancies are now filled. The Lead Medical Examiner has now been in post for a few months. Five additional medical examiners, covering a range of directorates, including anaesthetics, acute medicine, oncology, palliative care and paediatrics will all be starting within the next month. Two full-time medical examiner officers will be starting on 16 November 2020 and will provide the administrative support for the service. The appointment of the medical examiner officers is crucial as they will help structure the process that is required. The team are looking to commence the first reviews toward the end of November 2020 and will also be doing some educational work with trainee doctors and attending divisional Patient Safety and Quality Board (PSQB) meetings to make colleagues aware of their work.

ACTION: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.

RESPONSIVE

182/20 QUALITY PRIORITY – IMPROVE RESOURCES FOR DISTRESSED RELATIVES / BREAKING BAD NEWS RELATING TO END OF LIFE CARE

Lindsay Rudge (Deputy Director of Nursing) presented appendix H, updating on the above quality priority.

As part of the response to COVID-19, a telephone bereavement service was established to ensure that families and relatives were supported during the pandemic, which has been informative to understanding the needs of families and been an important service which has received powerful feedback. The service has been supported by End of Life Team, specialist nurses and volunteers and will be evaluated to understand how sustainable it will be moving forward.

As a result of some of the feedback from families and relatives, a pre and post bereavement quality standard is being developed to support wards to understand the feedback received from relatives.

Work is also ongoing with the West Yorkshire and Harrogate Cancer Alliance on breaking bad news, and the Community Palliative Care Services in Calderdale on how they support distressed relatives, break bad news and how they follow-up with patients. There has been a sustained growth in demand for the service, and LR gave credit to the team in maintaining the service through the pandemic.

OUTCOME: The Quality Committee received and noted the report.

183/20 CANCER BOARD REPORT

Christopher Button (Lead Cancer Nurse) was in attendance to provide any update from the Cancer Board, as detailed in the report at appendix I.

The report covers the meeting held on 7 October 2020, which was the first meeting held since January 2020, due to COVID-19. Following the first peak of COVID-19, a series of stabilisation and reset groups were commenced for all the cancer groups.

In the last update to the Quality Committee, it was reported that the Board would have patient representation for the first time. Two people were identified to support the Board on an alternate basis, however, one of the identified individuals, Steve Thackary, who was due to join in October 2020, sadly died, which was a huge blow to the Board, as he was a massive influence in helping shape some of the services over the last few years.

The key points of the report were noted including the 104-day cancer breeches; Multi-disciplinary team pledge follow-ups; Performance and benchmarking; patient stratified follow-up (PSFU) and patient-initiated follow-up (PIFU), and patient health and wellbeing offering.

In relation to the patient-initiated follow-up and the patient health and wellbeing, LR asked if there has been an inclusive approach to all communities, and whether all community groups are being represented across the breadth of health inequalities. CB reported that this is a very personalised approach and based on a holistic-needs assessment of all patients. Part of the work of the health and wellbeing links with patient-initiated follow-up, as it is around patient education and information, and further engaging with groups which are not currently reached.

DS stated that it would be useful for CB to liaise with RW in relation to patient experience.

OUTCOME: The Quality Committee received and noted the report.

184/20 BI-MONTHLY QUALITY REPORT

Doriann Bailey (Assistant Director of Patient Safety) presented appendix J with a bi-monthly update on key quality and patient experience outcomes for August to September 2020.

The key points to note were:

- some outstanding actions from the 2018 CQC inspection. The Trust still have five actions to complete, and the expectation from the CQC response group is that these actions will be closed by the end of November 2020.

- The Focused Support Framework pilot has been undertaken and ward 21 was completed last week. Outcomes from the report will be discussed, and plans are underway to develop a more multi-professional process.

- The Trust continues to be an outlier with Central Alert System (CAS) alerts, showing nationally as "much worse". Further improvement work is needed to address this position, in order to report an improved position going forward.

- Work is ongoing to provide further assurance in relation to risk mitigations for recommendations nine and 10 on the Trust's position for Facing the Future Standards for Children in Emergency Care settings.

- The Trust will undergo a CQC Patient FIRST for ED review, and the meeting will take place on 30 October 2020. A lot of work is ongoing with ED in preparation, and the report and outcomes will be brought back to this meeting.

- Pressure Ulcers – there is a reduction to two areas of limited assurance, noting an improving position with reasonable assurance across six areas. In quarter one, we were presented with a greater figure and whilst it is recognised that numbers went up in September, we are in a better position in quarter 3.

- Venous Thromboembolism (VTE) – there has been a great achievement of the 95% target of patients being risk assessed for developing a VTE.

- There are plans in place to improve reporting around quality indicators across the Trust.

EA also reported on the agreed focused quality priorities and work being undertaken with health informatics colleagues around developing a quality dashboard. Work is also ongoing with operational performance colleagues to ensure there is appropriate duplication, and the removal of any inappropriate duplication.

In relation to the Facing the Future Standards, EA reported that these are 70 standards developed by the Royal College of Paediatrics and Child Health (RCPCH). CHFT, along with many other organisations are currently not compliant with some of the standards and are in breach of a regulation as a result. There is recognition by CQC of this and CHFT have done a phenomenal amount of work, particularly in the last four weeks in order to get ourselves back in compliance. There is another risk issue around paediatrics which is around our two-site model. EA suggested that the paediatric team and a matron from the emergency department are invited to this meeting to talk about their plans on how to manage the risk of a split-site paediatric service in light of staffing shortages.

ACTION: Gill Harries and Louise Croxall to be invited to a future Quality Committee to discuss their plans to manage the risk of a split-site paediatric service.

EA thanked DBy for providing the report despite being recently in post.

OUTCOME: The Quality Committee received and noted the report.

185/20 QUALITY ACCOUNT

Andrea Dauris (Associate Director of Nursing - Corporate) was in attendance to present appendix K, the final version of the 2019 Quality Account.

A draft report was previously presented at the Quality Committee on 3 August 2020, with comments requested from stakeholders and updates on all four quarters of the guardians of safe working for 2019/2020 incorporated into this final version.

DS stated that the Quality Committee have been delegated responsibility by the Board of Directors to approve the Quality Account.

OUTCOME: The Quality Committee approved the quality Account.

186/20 INTEGRATED PERFORMANCE REPORT

The integrated performance report is due to be published on 29 October 2020, therefore unavailable for this meeting.

WELL-LED

187/20 BOARD ASSURANCE FRAMEWORK

Andrea McCourt (Company Secretary) presented appendix M, the second update of the Board Assurance Framework (BAF) which will be submitted to the Board of Directors on 5 November 2020.

The BAF risks are more strategic in nature than those on the high-level risk register, and the long-standing risks have been reviewed. Risk 9/19 - HRI estate and equipment (impact quality) has been revised and will be owned by the Finance and Performance Committee, not the Quality Committee as previously reported. There have been no movement in scores since the last update, and there was a risk around compliance with NHS England / Improvement which included elements of the CQC well-led governance framework, however, following discussion with EA, this has been removed and added into BAF risk 4/20 - CQC rating.

DS noted that the Quality Committee now have responsibility for four BAF risks, and deep dives will be carried out on all four risks from November 2020 through to February 2021.

OUTCOME: The Quality Committee noted the report.

188/20 INTERNAL AUDIT REPORT – CLINICAL AUDIT

Andrea Dauris (Associate Director of Nursing - Corporate) was in attendance to present appendix N, the findings of the internal audit report for the clinical audit service, which resulted in an overall opinion of significant assurance.

The report describes areas of significant assurances and some areas where processes were not robustly followed. An action plan was available in the report which reflects the areas of further development against a number of moderate recommendations, which will be monitored by the Clinical Effectiveness and Audit Group chaired by Dr Elizabeth Loney (Associate Medical Director).

OUTCOME: The Quality Committee noted the report.

POST MEETING REVIEW

189/20 MATTERS TO REPORT TO THE BOARD OF DIRECTORS

- Comprehensive update received from maternity services on their SAFE improvement plan
- Making Complaints count bundle received, and recommendations endorsed in the service review paper
- 2019 Quality Accounts approved
- Quality report has escalated a number of concerns, including the CAS alerts and non-compliance with the paediatric facing the future standards
- Learning from death quarterly report received and will be linking of the SJR themes to support improvement projects going forward

190/20 REVIEW OF MEETING

What went well….

- There was a large agenda, however, there was a good balance between brevity and time spent on each item, and discussion was allowed where needed
- Reports were not deferred due to non-attendance
- Reporters were very clear when presenting their relevant reports

What could be better……

- Feedback from report authors / presenters would be appreciated on whether they have appropriate time to present

191/20 ANY OTHER BUSINESS

Board Assurance Framework risks on workplan

The four BAF risks to be added to the workplan

ITEMS TO RECEIVE AND NOTE

192/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix O and will incorporate the four BAF risks as noted above.

193/20 QUALITY COMMITTEE 2021 MEETING DATES

The meeting dates for 2021 were available at appendix P.

NEXT MEETING

Monday, 30 December 2020 at 3:00 – 5:00 pm on Microsoft Teams

Meeting scheduled for Monday; 30 November 2020 stood down

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 26 OCTOBER 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS				
26.10.20 (177/20	**MAKING COMPLIANTS COUNT**	Rachel White	**Action 26.10.20**: A position statement following discussion at WEB to be resubmitted to the Quality Committee.	**See agenda item 198/20**
2.9.20 (132/20)	**QUALITY PRIORITY - MEDICAL DEVICES**	Divisions	**Action 2.9.20:** Medical devices training and maintenance to be added as a risk on divisional risk registers Update September 2020: MA to check with all divisions that this is on risk registers. Update October: Surgical division working to place risk on register; work ongoing in FSS division; awaiting feedback from Community and Medical divisions. **Update 26.10.20: JOR reported that the FSS division have discussed this, with progress made in several areas and training continuing. In relation to medical device maintenance, further information has been requested from Medical Engineering, however, this has not yet been received. Once all information has been gathered, this will ascertain what the risks are.** **Update November: Following a meeting with Doriann Bailey, Robert Ross and the Quality Governance Leads, it has been agreed that this is put on hold until the New Year. Medical devices training is now on the Community Risk Register at 7912.**	
2.9.20 (133/20)	**QUALITY PRIORITY – FALLS RESULTING IN HARM**	Helen Hodgson / Dr Abhijit Chakraborty	**Action 2.9.20**: HH to take comments back to the Falls Collaborative to reconsider the 10% reduction target and to provide further assurance to the Quality Committee **Action 2.9.20**: The equality impact assessment to be completed. **Action 2.9.20**: Benchmarking data from other Trusts to be added to the monthly falls dashboard. **Update 26.10.20: Reminders sent on 1 October and 20 October – no response received as yet. Further update to be requested from the Falls Collaborative.** **Update November: Deadline date provided for update**	**See matters arising**
5.2.20 (21/20)	**OUTPATIENTS IMPROVEMENT PLAN**	Kimberley Scholes	**Action 5.2.20:** Progress on actions from the outpatient's improvement plan to be provided in April 2020. **Update June 2020:** Awaiting steer from Executive Director of Nursing due to a number of amber/red actions which need clarity in the context of COVID-19 **Action 28.9.20:** A more detailed report and the status of the original action plan was requested **Update October: Updated report received and will be circulated to Quality Committee for comments ahead of next meeting. Discussion to take place at next meeting if necessary.** **Update: Follow-up report attached**	**See attached**
29.6.20 (103/20)	**INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK**	David Birkenhead	It was stated that in the future, it would be good to get an update on how the recommendations have been implemented, and DB agreed that an action plan with an assurance statement against the 10 standards and any new guidance that has been issued, can be brought back to the Committee. **Action 29.6.20**: Action plan to be brought back to the Committee at a later date. **Update August:** Progress report will be made available for 28 September 2020 meeting **Update Sept**: To be deferred **Update 26.10.20: DB requested an extension to revise the report, due to continuous changes in guidance and extra support within the Infection Control team to assist with this. An update to be provided at next meeting.** **Update November: See agenda**	**DUE Wednesday, 30 December 2020**
2.9.20 (140/20)	**COMMUNITY DIVISION REPORT**	Community division	**Action 2.9.20:** Feedback on the development of non-concordance in relation to pressure ulcers to be provided in the next quarterly report. **Update November: See agenda**	**DUE Wednesday, 30 December 2020**
FORTHCOMING ACTIONS				
3.8.20 (121/20)	**QUALITY COMMITTEE ANNUAL REPORT ACTION PLAN**	Chair	**Action 3.8.20: An action plan will be submitted to the Committee once the results have been reviewed.**	**DUE Monday, 25 January 2021**
26.10.20 (184/20)	**BI-MONTHLY REPORT**		**Action 26.10.20:** Gill Harries and Louise Croxall to be invited to a future Quality Committee to discuss their plans to manage the risk of a split-site paediatric service.	**TBC**
1.7.19 (120/19) 2.3.20 (41/20)	**SERIOUS INCIDENTS DEEP DIVE**	Maxine Travis	**Action 1.7.19**: OW to be invited to a future meeting to present next steps. **Update 29.7.19:** Work is ongoing to review systems and processes, with an action plan being pulled together. **Update 30.9.19:** A three-month update was provided – see item 176/19 **Action 30.9.19**: Further update to be provided in six months' time, and maybe earlier if improvement and sustained change is not noted. **Update 2.3.20:** Following discussion on target timescales of between 25 to 40 working days for responding to complaints, it was queried why the same timescale cannot be delivered for serious incidents. **Action 2.3.20: Deep dive into serious incidents to take place.** **Update September: MT reported that a conversation with the new Assistant Director for Patient Safety will need to take place regarding plans going forward with serious incident investigation capacity. This item to be deferred.**	**TBC**
26.10.20 (181/20)	**MEDICAL EXAMINER UPDATE**	Dr Tim Jackson	Following a verbal update from CP, it was agreed that Dr Tim Jackson is invited to the next Medical Examiner's update in April 2021 **Action 26.10.20**: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.	**Monday, 19 April 2021**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 30 December 2020

STANDING ITEMS

194/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Dr David Birkenhead **(DB)**	Medical Director
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Christine Mills **(CM)**	Public-elected Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Gareth Webb **(GW)**	Interim Senior Risk Manager
Rachel White **(RW)**	Assistant Director for Patient Experience
Debbie Winder **(DW)**	Head of Quality, Greater Huddersfield CCG
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Ian Craig **(IC)**	Head of Legal Services (observing)
Philip Lewer **(PL)**	Chairman (observing)
Helen Marshall **(HM)**	Project Manager (item 198/20)
Elizabeth Morley **(EM)**	Associate Director of Nursing – Community (item 209/20)

195/20 APOLOGIES

Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development

196/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

197/20 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Monday, 26 October 2020 were approved as a correct record. The meeting scheduled for Monday, 30 November 2020 was stood down.

The action log can be found at the end of the minutes.

AD HOC REPORTS

198/20 IMPACT ASSESSMENT PROCESS FOR SERVICE CHANGES

Helen Marshall (Project Manager) was in attendance to present the Impact Assessment Process development paper at appendix B, summarising that both the quality impact assessments (QIA) and equality impact assessments (EqIA) have been revised and a new process has been developed for service change, which introduces a more robust review process. This is currently in the testing phase.

Following discussion on the revised process, the positive feedback received to date, and the forms being accessed via the intranet from January 2021, KH and DS commented on looking forward to seeing a completed assessment in the future.

HM was thanked for the update on the new impact assessment process.

OUTCOME: The Committee received and noted the report.

199/20 NATIONAL PATIENT SAFETY ALERT: SUPERABSORBENT POLYMER GEL GRANULES

Elisabeth Street (Clinical Director for Pharmacy) and Ellen Armistead (Director of Nursing) presented appendix C, a paper to support the use of superabsorbent polymer gel, commonly known as Vernagel.

Vernagel has been in use in the NHS for some time, largely in relation to small-scale spills and used in urinals. Across the country, there have been incidents of harm or death where patients have either ingested the polymer gel or suffered asphyxiation, and a safety alert was issued in July 2017 with clear guidance that firm risk assessments are needed. The Trust responded to the actions instructed by the alert in 2017, and a further national alert was issued in September 2019, and again the Trust reviewed actions required.

In August 2020, there was a near-miss incident, where a patient came to no harm, however, further action was taken in the form of an urgent task and finish group to review areas that were using the gel and carry out a risk assessment. CHFT is expected to continue to use Vernagel in permitted areas with tighter controls on its use and storage.

The Committee were asked to note that levels of assurance were provided in relation to the alerts prior to the incident, when risk assessments were repeated. It is recommended that continuous audits on the use and storage of superabsorbent polymer gels take place.

In relation to the risk assessment for using superabsorbent gel or granules for the denaturing of controlled drugs prior to destruction, the safest options were for:

- Medi-gel sachets for use in theatres and endoscopy - any spare sachets are locked away and not in areas where patients are left unattended.
- Denaturing kits for use by pharmacy on ward areas - if patients need their own drugs denaturing, the pharmacy team attend the ward and use the kits, which are then locked in a clinic cupboard and disposed of.

The safe storage of denaturing kits and gel sachets have been added to the controlled drug audit, which is carried out by the Pharmacy team in all areas, at a minimum of twice per year.

In relation to areas that use Vernagel super absorbent sachets, but do not stock controlled drugs therefore, will not be audited by pharmacy as part of their safe storage of controlled drugs audit, DBy asked how it will be assured that there are no missed opportunities in the monitoring and auditing of those areas. EA stated that this should form part of the matron's audit, and that a spot-check audit takes place in six months' time to ensure compliance in dermatology CRH, angiography CRH and radiography HRI, as outlined in the appendix of the report.
Action: DBy to contact Jean Robinson (Senior Infection Control nurse) to add the superabsorbent polymer gel check to the frontline ownership (FLO) audit.

In relation to any areas of non-compliance reported to the Medication Safety and Compliance Group, DS asked what action would be taken thereafter. ES stated that the matron and Associate Director of Nursing will be notified of any deviations of the controlled drugs audits, and would expect confirmation from the ward manager on what mitigations are being put in place and whether support is needed from Pharmacy or the matron, to ensure that non-compliance does not continue.

DBy thanked ES for carrying out this work to close the patient safety alert.

OUTCOME: The Committee noted and approved the recommendations in the report.

200/20 MAKING COMPLAINTS COUNT

Rachel White (Assistant Director of Patient Experience) presented appendix D and provided an update on any exceptions following submission to the Weekly Executive Board this month.

These exceptions include moving to a place where the complaints service is more user-led; and creating a collaborative approach to address any challenges. The first collaborative meeting will be held on 19 January 2021, and the Committee were asked to note the exceptions as detailed in the report and to endorse that the membership of the co-design project team is held to account for success, via the quarterly progress reports.

KH commented on the £800 cost implication for support for all staff and bespoke support for investigators and asked if this has now been agreed. RW stated that the collaborative is yet to develop the workplan and put forward a shared business case with divisions to support the delivery of this.

DS commented on the initiative of using redeployed staff to assign a mini team to operate alongside the existing quality leads in each division and asked how long it would take to get the mini team together. RW stated that the mini teams were already put in place, with mixed success, and are now in the process of being brought back into the central complaints team, and predominantly working on long-standing complaints that have breached. One of the early successes noted is the quality of the reports following the revised way of working. RW stated that the pace of this work will change by trying to respond to the needs of the divisions.

DS also commented on delays and handoffs with complaints that covered more than one division or directorate and asked how this is being addressed. RW reported that the focused improvement work is not taking place as yet, however, it is one of the issues that has been recognised, and one of the tasks of the collaborative is to carry out a process map to understand the handoffs and delays that may be experienced at each stage. Once this is understood, steps can then be taken to streamline the process more efficiently and effectively.

DS mentioned that the report stated the plan will take between one and three years to develop, and asked that in the next report, the collaborative provides an indication of where the process is expected to be in a years' time.

OUTCOME: The Committee noted the exceptions and endorsed the membership of the co-design project team to be held to account for success, via the quarterly progress reports.

CARING

201/20 QUALITY PRIORITY – LEARNING LESSONS TO IMPROVE PATIENT EXPERIENCE

Rachel White (Assistant Director for Patient Experience) presented appendix E, which was detailed in the report provided at item 200/20. RW summarised that previous work has taken place in relation to the learning portal, and further discussions are needed on what this work entailed.
Action: Further update to be provided once this is known.

SAFE

202/20 INFECTION PREVENTION AND CONTROL (IPC) ACTION PLAN AND UPDATE ON IPC BAF RECOMMENDATIONS

Dr David Birkenhead (Medical Director) presented appendix F highlighting the work carried out on the IPC action plan.

An initial assessment was made against the Board Assurance Framework and work continued to provide further assurance around progress. The assurance which was independently verified provided good compliance with the requirements of infection prevention and control

and have clearly tried to keep up with guidance that has developed as the knowledge base has increased. There are still some challenges, largely in relation to the estate, and ongoing challenges around social distancing which are not just within CHFT, but also in the broader community.

In terms of the amber actions:

- Social distancing - all clinical and non-clinical areas now have a social distancing risk assessment and an ongoing assurance process around compliance with those guidelines
- Prevalence/incidence rate for COVID - pathways are identified to ensure that suspected COVID patients are not mixed with those that are known to be non-COVID or COVID-positive, as it is a pressure on side room capacity. Any occurrence of an incident is reported on Datix.
- Ventilation – this is still challenging, particularly in the accident and emergency department, with the purchase of high-efficiency particulate air (HEPA) filtration machines, which recirculate air through a HEPA filter to remove viral particles. It is uncertain whether this impacts on the transmission of COVID.

It was stated that progress on the action plan have been made, and an updated plan will be brought to a future meeting.

KH asked DB, from a clinical perspective, whether he was in agreement with the reduction of risk 7685 (PPE supply chain) on the risk register (appendix H). DB reported that there have been no issues with the supply of PPE for some time, and that national supplies have largely held up, with more manufacturing capacities within the UK to produce PPE.

DS asked about the recommendation of improving compliance with the COVID 5-day retest swab. DB reported that this is improving and now introducing a 3-day test following recent guidance. Daily reports on compliance with 5-day testing are placed on the knowledge portal in order for divisions to report on every day. The 5-day swabs are being done by 8:00 am to facilitate the admission of the 3-day swabs. The performance metrics for these will be updated at a future meeting.

DS also commented on the recommendation relating to a record of training to be included for all staff and linked to the electronic staff record (ESR). It was asked whether the functionality issues will be resolved soon, and DB noted that this is in relation to fit-testing, stating that there is good visibility on who has and has not been fit-tested, at this point in time. LR stated that there are currently multiple devices to record training, and the functionality of ESR at the time of review did not bring any benefit, and would have taken considerable work to try to get ESR to link to an individual and every different mask used in the Trust, and record against that. Another issue is that the Trust's supply of masks can change, therefore, ESR would need to be updated, however, this change can be done more quickly on the separate database than ESR at this moment at time. The PPE Group felt that the improvement of the functionality of the existing database can provide assurance.

203/20 INFECTION PREVENTION AND CONTROL BOARD REPORT

Action: Report to be submitted to the next meeting.

204/20 HIGH LEVEL RISK REGISTER

Gareth Webb (Interim Senior Risk Manager) presented appendix H highlighting the high-level risk register as at 8 December 2020.

It was noted that all high-level risks have gone through a full review and all risks now include a current progress update and reviewed target dates.

The top seven risks scoring 20 and above are:

7454 (20): Radiology Staffing Risk
2827 (20): Over-reliance on locum middle grade doctors in A&E
6345 (20): Nurse staffing risk
7078 (20): Medical staffing risk
7689 (20): Waiting for diagnostics, operations and outpatients (COVID)
7683 (20): Lack of isolation capacity (COVID)
7474 (20): Medical devices

There were two new risks onto the high-level risk register: 7939 (social distancing – staff behaviours) and 7942 (overarching staffing risks); one increased risk 7474 (medical devices); one reduced risk 7685 (PPE supply chain) and one closed risk 7315 (delay in outpatient appointments).

EA stated that this high-level risk report is due for submission to the Board of Directors on 14 January 2021, and noted that four risks (7078 (medical staffing); 7248 (essential safety training); 7413 (fire compartmentalisation) and 7414 (building safety)) have now gone beyond their target dates. EA stated that it is the role of the Risk Group to carry out a deep dive into those risks and either keep the target date and accept that it has been missed, or reset a new target date, on the understanding that the risk must have a new set of actions following the review.

OUTCOME: The Quality Committee received and noted the report.

WELL LED

205/20 BOARD ASSURANCE FRAMEWORK (BAF) RISK – 3/19: SEVEN DAY SERVICES

Dr David Birkenhead (Medical Director) presented the deep dive of the board assurance framework risk at appendix I, highlighting the four priority standards on seven-day services: time to consultant review, access to diagnostic tests, access to consultant-directed intervention, ongoing reviews by consultants twice daily.

Prior to COVID, all four standards were compliant, and this was reported to NHS England / Improvement. Since the onset of COVID and a reporting mechanism change to the internal assurance process, CHFT were unable to complete the audit in the spring due to the high rates of COVID at that point in time, and similarly, in autumn, the second assurance audit was unable to be completed to assure compliance with the four standards.

In relation to the changes put in place around COVID, the situation has improved from an acute patient point of view, due to further resources being put into that aspect of care. It is expected that once resources are put in place to carry out the audits again, that compliance would be reported against the four standards.

There has been a recommendation to reword the risk to:

'Risk that the Trust will be unable to deliver appropriate services across seven days due to staffing pressures, resulting in poor patient experience, greater length of stay and reduced quality of care'

KH commented that although the audit has not yet taken place, there is assurance via the mitigating actions in place. DB stated that every effort will be made to complete the audit to provide the Quality Committee with a level of assurance of in relation to compliance.
Action: DB to follow this up with CP, DBy and RW regarding resources needed to complete the audit

OUTCOME: The Quality Committee approved and supported the rewording of the risk.

PATIENT SAFETY AND QUALITY BOARD QUARTER 2 REPORTS

206/20 FAMILIES AND SPECIALIST SERVICES DIVISION

The report was provided at appendix J, however, due to clinical pressures, no representative from the division was in attendance to present the report.

The terms of reference of the division's Patient Safety and Quality Board meetings were also circulated for ratification from the Quality Committee, and it was noted that the administrative support on the terms of reference would need to be revised, as well as the addition of divisional patient experience and quality support leads on the membership of the PSQBs.

Action: The terms of reference to be returned to the division for the relevant amendments to be made and returned to the Quality Committee for ratification.

OUTCOME: The Quality Committee noted the report.

207/20 MEDICAL DIVISION

The report was provided at appendix K, however, due to clinical pressures, no representative from the division was in attendance to present the report.

OUTCOME: The Quality Committee noted the report.

208/20 SURGERY AND ANAESTHETICS DIVISION

The report was provided at appendix L, however, due to clinical pressures, no representative from the division was in attendance to present the report.

OUTCOME: The Quality Committee noted the report.

209/20 COMMUNITY DIVISION

Elizabeth Morley (Associate Director of Nursing) was in attendance to briefly present appendix M, summarising the headlines from quarter 2, including:

- Increase in rates of palliative care referrals – this is well discussed within the division and escalated to the Director and Deputy Director of Nursing. Support provided to the existing palliative care team from other nursing services to cope with the increase in demand for the service. It has been identified that patients who are at their end of life are opting to die at home rather than a hospice setting, which is driving the increase in referrals.
- Diabetic pathway – there was an increase in referrals for support for patients who need to have insulin at home. A piece of work is ongoing for the future on supported self-management by training patients to deliver their own insulin. There is ongoing work with opportunities to train healthcare assistants to administer insulin, and some competencies are in place for healthcare assistants to help the registered nursing workforce in delivering insulin.
- Virtual complex wound clinics – the division often find that patients don't necessarily inform nurses if a wound is deteriorating, and access to expertise in that field is often an opportunity missed, therefore, an expert panel has been developed, consisting of a tissue viability nurse, and some senior nurses from the division and a vascular expert, where community nurses can present their cases of complex wounds to the panel for expert advice. This creates a quicker referral process before a visit is arranged.
- The division have set up a wound clinic within the Ebenezer centre in Halifax, where the homeless can get a hot meal and help and support from social services, and community services have been allowed to set up a clinic to support those who are homeless and may have leg ulcers, etc, and can be treated in that setting. This resource was well received in

the community, but needed to be scaled down due to COVID, as nurses were needed elsewhere.

- Concern regarding increase in demand for syringe drivers, with some patients requiring three to four drivers at a time. Work has been done with colleagues in the acute setting regarding providing a pool where access to syringe drivers can provided. Due to the increase in demand, this has created an issue with equipment. This is on the risk register and monitored daily.

KH queried staff morale and the absence rate within community services. EM stated that the absence rate is variable on a day-to-day basis, due to on-day COVID-related sickness which can include staff who are symptomatic or those isolating. Morale is also variable, however, several areas of support for staff are available and it has been noted that community colleagues are taking good advantage of the health and wellbeing hour and aware of and accessing services when they need further support, especially palliative care colleagues who have been impacted by dealing with verification of death and increasing support with bereaved families.

DS noted challenges in the community regarding entering patient's homes and social distancing and asked whether community colleagues have any additional personal protective equipment (PPE) which is provided to alleviate any concerns with personal safety. EM reported that no additional PPE is provided, however, all colleagues follow national guidance and strict rules when putting on and taking off (donning and doffing) PPE in a patient's home or care home, so they are not at risk of other exposure. Patients are contacted before a visit is made to ask if anyone is in the home with them, and COVID checks include the patient and other household members.

EA acknowledged EM's leadership with the community team, who have responded to a host of challenges and done so with good grace. EA was very grateful to EM and the team.

OUTCOME: The Quality Committee approved and supported the recommendations from the report.

RESPONSIVE

210/20 INTEGRATED PERFORMANCE REPORT

Ellen Armistead (Executive Director of Nursing) presented appendix N and briefly summarised the overall Trust performance for November 2020 reporting a deterioration in month.

There continues to be an issue with complaints, as previously discussed at item 200/20. The cancer 62-day screening and 38-day referral have also had some deterioration in month and understandably relates to COVID and the delays that some patients are experiencing. The clinical prioritisation work is focussing on those of greatest need and going through an internal review of all patients on the list and reinstating some theatres over the next few weeks to get through the backlog.

The Summary Hospital-level Mortality Indicator (SHMI) has gone above 100 for the first time in 12 months, and Dr David Birkenhead (Medical Director) and Dr Cornelle Parker (Deputy Medical Director) have been asked to carry out some in-depth work to ascertain any link with COVID.

A deep dive into the 12-hour trolley waits will be presented at the next Quality Committee meeting, and it was noted that the position has significantly improved.

A number of stroke outcome targets have been missed, with some relating to cross-site issues, some to pressures from a COVID and non-COVID perspective, and also issues with the Yorkshire Ambulance Service (YAS) who are under pressure as they respond to the pandemic.

It was stated that a deep dive on clinical prioritisation may be needed at the February Quality Committee meeting.

211/20 BI-MONTHLY QUALITY REPORT

Doriann Bailey (Assistant Director of Patient Safety) presented appendix O with a bi-monthly update on key quality and patient experience outcomes for the period of October to November 2020.

DS commented on the outstanding actions in relation to the serious incidents and asked how this is being progressed in a supporting way to close the long-standing actions. DBy reported that the incident team are going through the system in a methodical way to review the outstanding actions and working with the owners and encouraging them to close them as soon as possible.

EA stated that following the Ockenden Review, a maternity section is now needed in the report to have an overview of the Healthcare Safety Investigation (HSIB) cases, and serious incidents and an update on the Ockenden Review.

EA also noted that the response needed for the Ockenden review has now been completed and returned, with a further response to be submitted by 15 January 2021. Going forward, it was noted that a dedicated maternity section will be added as part of this report and that Karen Heaton has stepped forward as the Trust's maternity safety non-executive director.

OUTCOME: The Quality Committee received and noted the report.

POST MEETING REVIEW

212/20 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

The Quality Committee received:

- The process for management and governance of impact assessments to service change
- An overview to the response to the national patient safety alert relating to superabsorbent polymer gels and the follow-up actions to prevent occurrence of a similar incident
- An exception report to the 'Making Complaints count bundle', and approved recommendations in terms of the co-design project team
- An update from the IPC action plan and reviewed the amber actions from the plan
- An update on concentrated work taken place with the high level risk register in getting it updated
- The Board Assurance Framework risk on seven day services and approved the rewording of this risk.

213/20 REVIEW OF MEETING

What went well….

- Good discussion on the Infection Prevention and Control action plan
- Good discussion on complaints

What could be better……

- If divisions were in attendance

DS noted that a review will take place on a month-by-month basis as to whether the Quality Committee meetings will continue or be stood down, as we move into challenging months. DS also noted as Chair of the Committee to make a commitment to try and keep the meetings to a maximum of one and a half hours, during the upcoming difficult and challenging months.

RW also noted that the Patient Experience and Caring Group meetings have been stood down to try to relieve pressures and that any items will be escalated to the Quality Committee as necessary.

CM thanked colleagues for their work in both hospitals and the community over the last year and hoped that next year is much better.

214/20 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

215/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix P for information.

NEXT MEETING

Monday, 25 January 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 26 OCTOBER 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS				
30.12.20 (199/20)	**Superabsorbent polymer gels**	Doriann Bailey	In relation to areas that use Vernagel super absorbent sachets, but do not stock controlled drugs therefore, will not be audited by pharmacy as part of their safe storage of controlled drugs audit, DBy asked how it will be assured that there are no missed opportunities in the monitoring and auditing of those areas. EA stated that this should form part of the matron's audit, and that a spot-check audit takes place in six months' time to ensure compliance in dermatology CRH, angiography CRH and radiography HRI, as outlined in the appendix of the report. **Action 30.12.20**: DBy to contact Jean Robinson (Senior Infection Control nurse) to add the superabsorbent polymer gel check to the frontline ownership (FLO) audit. **Update: JR agreed to add compliance checks to the FLO audit**	
30.12.20 (201/20)	**Quality priority – learning lessons to improve patient experience**	Rachel White	Rachel White (Assistant Director for Patient Experience) presented appendix E, which was detailed in the report provided at item 200/20. RW summarised that previous work has taken place in relation to the learning portal, and further discussions are needed on what this work entailed. **Action 30.12.20**: Further update to be provided once this is known. **Update: See matters arising**	**See matters arising for update**
30.12.20 (203/20)	**Infection prevention and control board report**	David Birkenhead	**Action 30.12.20**: Report to be submitted to the next meeting. **Update: See agenda item 12/21**	**See agenda item 12/21**
30.12.20 (205/20)	**BAF Risk 3/19: seven-day services**	David Birkenhead	DB stated that every effort will be made to complete the audit to provide the Quality Committee with a level of assurance in relation to compliance. **Action 30.12.20**: DB to follow this up with CP, DBy and RW regarding resources needed to complete the audit **Update: Completion of audit to be confirmed**	
30.12.20 (206/20)	**FSS Terms of Reference**	FSS Division	The terms of reference of the division's Patient Safety and Quality Board meetings were also circulated for ratification from the Quality Committee, and it was noted that the administrative support on the terms of reference would need to be revised, as well as the addition of divisional patient experience and quality support leads on the membership of the PSQBs. **Action 30.12.20**: The terms of reference to be returned to the division for the relevant amendments to be made and returned to the Quality Committee for ratification. **Update: Action forwarded to division**	
2.9.20 (133/20)	**Quality priority – falls resulting in harm**	Denise Sterling	**Action 2.9.20**: HH to take comments back to the Falls Collaborative to reconsider the 10% reduction target and to provide further assurance to the Quality Committee **Action 2.9.20**: The equality impact assessment to be completed. **Action 2.9.20**: Benchmarking data from other Trusts to be added to the monthly falls dashboard. **Update 26.10.20:** Reminders sent on 1 October and 20 October – no response received as yet. Further update to be requested from the Falls Collaborative. **Update November:** Deadline date provided for update **Update 30.12.20:** Update received from Falls Collaborative as attached. Discussion ensued on the response received and it was agreed that it should be referred to the Clinical Director for the medical division. The Chair noted that the response did not provide assurance on the safety of patients in terms of falls. It was also noted that complex complaints of repeated falls are currently taking place and could be avoided if a robust falls programme is in place. In relation to IT support and provision of fall sensors, it was agreed that these risks are highlighted in a paper for from the Falls Collaborative and escalated to the Quality Committee. **Action 30.12.20**: DS to follow this up with the Clinical Director for the medical division. **Update: Chair actioned with Clinical Director**	
FORTHCOMING ACTIONS				
26.10.20 (184/20)	**Bi-monthly report**	Gill Harries, Louise Croxall, Julie Mellor	**Action 26.10.20:** Gill Harries and Louise Croxall to be invited to a future Quality Committee to discuss their plans to manage the risk of a split-site paediatric service.	**DUE Monday, 22 February 2021**
5.2.20 (21/20) 28.9.20 (154/20) 30.12.20 (matters arising)	**Outpatients improvement plan**	Helen Barker	**Update 30.12.20:** In relation to the update received from the outpatients' action plan, EA noted that reference to the risk register is made in relation to a closed risk on outpatient delays, however, the risk relates to a new risk on COVID-related delays. Due to the change in circumstances due to the delays as a result of COVID, could HB attend QC to provide updates on all outpatient risks that have been included in the COVID-related risks, as there have now been changes. **Action 30.12.20:** That Helen Barker attends to provide update on outpatient COVID-related risks	**DUE 22 March 2021**
26.10.20 (181/20)	**Medical examiner update**	Dr Tim Jackson	Following a verbal update from CP, it was agreed that Dr Tim Jackson is invited to the next Medical Examiner's update in April 2021 **Action 26.10.20**: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.	**DUE Monday, 19 April 2021**
1.7.19 (120/19) 2.3.20 (41/20)	**Serious incidents deep dive**	Senior Risk Manager	**Action 1.7.19**: OW to be invited to a future meeting to present next steps. **Update 29.7.19:** Work is ongoing to review systems and processes, with an action plan being pulled together. **Update 30.9.19:** A three-month update was provided – see item 176/19 **Action 30.9.19**: Further update to be provided in six months' time, and maybe earlier if improvement and sustained change is not noted. **Update 2.3.20:** Following discussion on target timescales of between 25 to 40 working days for responding to complaints, it was queried why the same timescale cannot be delivered for serious incidents. **Action 2.3.20: Deep dive into serious incidents to take place.** **Update September: MT reported that a conversation with the new Assistant Director for Patient Safety will need to take place regarding plans going forward with serious incident investigation capacity. This item to be deferred.** **Update: Audit Yorkshire is in the process of commencing a deep dive of the incident management process.**	**DUE FOR CLOSURE**
CLOSED ACTIONS				
2.9.20 (132/20)	**Quality priority - medical devices**		**Action 2.9.20:** Medical devices training and maintenance to be added as a risk on divisional risk registers Update September 2020: MA to check with all divisions that this is on risk registers. Update October: Surgical division working to place risk on register; work ongoing in FSS division; awaiting feedback from Community and Medical divisions. **Update 26.10.20:** JOR reported that the FSS division have discussed this, with progress made in several areas and training continuing. In relation to medical device maintenance, further information has been requested from Medical Engineering, however, this has not yet been received. Once all information has been gathered, this will ascertain what the risks are. **Update November**: Following a meeting with Doriann Bailey, Robert Ross and the Quality Governance Leads, it has been agreed that this is put on hold until the New Year. Medical devices training is now on the Community Risk Register at 7912. **Update: Medical devices update to Quality Committee to be amended on the workplan**	**CLOSED Monday, 30 Dec 2020**
26.10.20 (177/20)	**Making complaints count**		**Action 26.10.20**: A position statement following discussion at WEB to be resubmitted to the Quality Committee. **Update 30.12.20: See item 200/20**	**CLOSED Monday, 30 Dec 2020**
29.6.20 (103/20)	**Infection prevention and control board assurance framework**		It was stated that in the future, it would be good to get an update on how the recommendations have been implemented, and DB agreed that an action plan with an assurance statement against the 10 standards and any new guidance that has been issued, can be brought back to the Committee. **Action 29.6.20**: Action plan to be brought back to the Committee at a later date. **Update August:** Progress report will be made available for 28 September 2020 meeting **Update Sept**: To be deferred **Update 26.10.20:** DB requested an extension to revise the report, due to continuous changes in guidance and extra support within the Infection Control team to assist with this. An update to be provided at next meeting. **Update November: See agenda** **Update 30.12.20: See item 202/20**	**CLOSED Monday, 30 Dec 2020**

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 26 OCTOBER 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
5.2.20 (21/20)	**Outpatients improvement plan**		**Action 5.2.20:** Progress on actions from the outpatient's improvement plan to be provided in April 2020. **Update June 2020:** Awaiting steer from Executive Director of Nursing due to a number of amber/red actions which need clarity in the context of COVID-19 **Action 28.9.20:** A more detailed report and the status of the original action plan was requested **Update October:** Updated report received and will be circulated to Quality Committee for comments ahead of next meeting. Discussion to take place at next meeting if necessary. **Update:** Follow-up report attached **Update 30.12.20:** Update received as attached, and a plan is in place for the 12 outstanding action plans to be addressed via other workstreams. KH noted KH that it was good that there has been progress and asked that assurance is provided in around nine months' time that the 12 actions have been sustained. EA noted that there are cross-references to the risk register in relation to closed risks on outpatient delays but is cross-references to a new risk on COVID-related delays. HB was asked that in February 2021, HB comes to the QC on updates on all outpatient risks that have been included in the COVID-related risks, as there have now been changes to the risks. **Action 30.12.20:** That a follow-up report is provided in October 2021 with a general update on whether all actions have been sustained. **Update: Kimberley Scholes invited to meeting on Monday, 11 October 2021 to provide update. Workplan amended to include update for October 2021**.	**CLOSED Monday, 30 Dec 2020**
2.9.20 (140/20)	**Community division report**		**Action 2.9.20:** Feedback on the development of non-concordance in relation to pressure ulcers to be provided in the next quarterly report. **Update November:** See agenda **Update 30.12.20**: **See item 209/20**	**CLOSED Monday, 30 Dec 2020**
3.8.20 (121/20)	**Quality committee annual report action plan**		**Action 3.8.20:** An action plan will be submitted to the Committee once the results have been reviewed. **Update: It was agreed that the action plan will be reviewed as part of the monthly agenda setting meeting between the Chair and MA.**	**CLOSED**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE
Review of Quality & Performance Report (Workforce)

Held on Wednesday 19 October 2020, 3pm – 4pm

VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Sharon Senior	(HS)	Staff Side Representative
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Ruth Mason	(RM	Associate Director of Organisational Development (for agenda item 53/20)

44/20 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

45/20 **APOLOGIES FOR ABSENCE:**

Ellen Armistead, Deputy Chief Executive/Director of Nursing
Helen Barker, Chief Operating Officer
Andrea McCourt, Company Secretary

46/20 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

47/20 **MINUTES OF MEETING HELD ON 10 AUGUST 2020:**

The minutes of the Workforce Committee meeting held on 10 August 2020 were approved as a correct record.

48/20 **ACTION LOG**

The action log was reviewed and updated accordingly.

49/20 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – SEPTEMBER 2020**

MB presented the report.

Summary
Performance on workforce metrics continues to be high although the Workforce domain remained at 76.1% in August 2020. This is now 16 consecutive months of a 'Green' domain.

Only 4 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Sickness Absence Rate' and 'Long term sickness absence rate' and 'Short term sickness absence rate'. The appraisal compliance for both medical and non-medical are not included in the Domain scoring due to postponement of appraisal season due and Covid-19 and will be included for non-medical at the end of the appraisal season.

Workforce – August 2020
The Staff in Post increased by 130.31 FTE, which, due, in part, to 36.96 FTE leavers in August 2020. There has also been an increase of 2.29 FTE in the Establishment figure, along with student nurses leaving.

Turnover increased to 6.98% for the rolling 12 month period September 2019 to August 2020. This is a slight increase on the figure of 6.8% for July 2020.

Sickness absence – July 2020
The in-month sickness absence decreased to 3.61% in July 2020. The rolling 12 month rate decreased marginally for the eleventh consecutive time in 21 months, to 4.25%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 38.57% of sickness absence in July 2020, decreasing from 40.58% in June 2020.

The RTW completion rate increased to 63.12% in July 2020.

Essential Safety Training – August 2020
Performance has improved in 7 of the core suite of essential safety training. With all 9 above the 90% target with 4 achieving the 95% 'stretch' target.
Overall compliance decreased to 94.42% and is below the stretch target following last month's rise above the stretch target for the first time in seven months.

Workforce Spend – August 2020
Agency spend increased by £0.11M, whilst bank spend decreased by £0.15M.

Recruitment – August 2020
3 of the 5 recruitment metrics reported (Vacancy approval to advert placement, shortlisting to interview, and Interview to conditional offer) deteriorated in August 2020. The time for Unconditional offer to Acceptance in August 2020 decreased and was just over 4 weeks.

DS noted that 3 out of 5 recruitment metrics have dipped in performance and asked what the challenges are. JE responded that a recent piece of work has identified that both data quality and practice issues are preventing targets being sustained month on month. A paper will be presented to the next committee meeting setting out the position and responses to achieve targets.

The Chair expressed that this was a positive report.

Action: Provide recruitment metrics report to the next committee meeting (CN).

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

50/20 **BOARD ASSURANCE FRAMEWORK (BAF)**

KH presented the BAF for comment. Four workforce risks are identified:

Medical Staffing; risk score 20 (target score 9)
Nurse Staffing; risk score 20 (target score 9)
Recruitment/Retention inclusive leadership; risk score 12 (target score 9)
Colleague Engagement; Risk score 9 (target score 3)

KH raised a concern in terms of staff turnover and staffing levels and how this would be managed in relation to spikes in Covid. SD advised that in response to phase 3 planning, conversations with divisions had identified priority roles which have subsequently been granted automatic vacancy approval. The safety of staff and patients was a primary focus and the likelihood of a covid surge was a factor in the Trust's phase 3 planning response.

The Committee approved the risks and associated scores for submission to the Audit and Risk Committee and the Board of Directors at its meeting on 5 November 2020.

OUTCOME: The Committee **RECEIVED** and **APPROVED** the BAF.

51/20 **COVID HEALTH AND WELLBEING PLAN UPDATE INCLUDING NO OF PEOPLE FRIENDLY EAR CONVERSATIONS**

SD avised that two weeks ago the Executive Board meeting focussed on identifying what actions are needed to attain an almost 100% response rate of the health and wellbeing risk assessment. The Trust's health and wellbeing activities can all be routed back to the analysis of the risk assessments. More recently a further 240 risk assessments have been received. Over 1300 friendly ear telephone calls have been made or received, with at least 3-5 colleagues at any one point needing significant input being referred to external support (Socrates).

A consolidated action plan has been developed using intelligence from risk assessments, results from friendly ear service and direct feedback. The action plan centres around a perfect storm response to ensure a 24/7 service. A request for funding was approved at the Commercial and Investments Strategy Group (CISG). The next priority is to increase risk assessment response rate and communicate clear messages around the must dos - social distancing, PPE, hand washing and being kind to each other.

SD advised there has been an increase in behavioural issues and this is a pattern seen across other Trusts. Any colleague going through an employee relations process is offered one culture of care wrap around support. The Committee noted that Occupational Health now provide a 7 day service to respond in particular to test and trace.

SD expressed thanks to colleagues involved working up the action plan.

KH asked how we compare to other Trusts. SD advised that our health and wellbeing risk assessment approach is different to other Trusts.

Action: Share action plan with Committee members (SD).

OUTCOME: The Committee **RECEIVED** and **NOTED** the Report.

52/20 **HEALTH & WELLBEING RISK ASSESSMENT RESPONSES**

3088 (appx 50% of the workforce) risk assessments have been received. SD advised of the enormous effort required to achieve this response rate and how challenging it would be to reach 100% response rate.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

53/20 **LEADERSHIP DEVELOPMENT PROGRAMME**

RM provided a summary of the presentation slides describing how the initial proposal transformed to a fully on-line programme. 1542 colleagues were enrolled onto the programme at its launch on 31 July 2020 with 40% of these colleagues having since

started the programme. The system allows tracking of individuals' progress across the modules. RM reported the programme is receiving excellent feedback from colleagues. The Committee noted the Chief Executive and Executive Directors have commenced the programme. KH asked what participant numbers would look like had the programme not been on-line. RM described the challenges of progressing 700 managers through a classroom based programme. DS enquired how long it would take to complete the programme content. RM advised approximately 5 hours plus participation in action learning sets.

KH and DS commended RM and colleagues on the good work.

OUTCOME: The Committee **RECEIVED** and **NOTED** the update.

54/20 **REVALIDATION AND APPRAISAL OF NON-TRAINING GRADE MEDICAL STAFF**

The annual report is submitted to the Workforce Committee to provide assurance that the agreed processes for GMC revalidation and appraisal have been adhered to prior to submission to the Board of Directors for sign off. The report provides a summary of work through to the end of March 2020 providing comparative data from previous years. DB highlighted the significant difference this year being the suspension of the appraisal and revalidation process by the NHSE/NHSI on 23 March 2020. 16 colleagues will be classed as 'approved missed appraisals'. The formal process will recommence in April 2021, however a soft start to appraisals was initiated in the Trust in October to provide a support function with conversations centering around health and wellbeing.

OUTCOME: The Committee **NOTED** the report and **SUPPORTE**D its submission to the Board of Directors.

55/20 **ANNUAL HEALTH EDUCATION ENGLAND TRUST SELF-ASSESSMENT REPORT**

The HEE Quality framework identifies the standards that organisations are expected to have in place to provide a quality learning environment for our learners. The Trust is required to assess annually which standards are fully or partially in place via the use of an annual self-assessment review (SAR). The purpose of the report is to make the Committee aware of the submission which has been made and provide assurance that the Trust complies with standards and domains as set out in the HEE Quality framework. DB pointed out a Significant point at section 4 – time given to consultants to fulfil their duties as a clinical supervisor or educational supervisor. The Trust doesn't meet the HEE expectation of 0 .25 programmed activity (PA) per trainee is offered. The Trust offers 0.125 PA for educational supervision and clinical supervision is expected to complete in general Supporting Professional Activity (SPA) allocation which is a total of 1.5 PAs. The Trust's offer hasn't changed in previous years but potentially may be challenged by HEE. DB confirmed that other Trusts give different allocations.

OUTCOME: The Committee **RECEIVED** and **NOTED** the Report.

56/20 **ANY OTHER BUSINESS**

No other business was raised.

57/20 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Board Assurance Framework
Revalidation and Appraisal of Non-Training Grade Medical Staff
Annual Health Education England Trust Self-Assessment Report
Positive update on Wellbeing
Leadership Development

In addition, SD requested that attendance at Workforce Committee is raised as a matter of concern at Board of Directors.

58/20 **DATE AND TIME OF NEXT MEETING:**

16 November 2020 (Deep Dive)
1pm – 3pm
Via Teams

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE
Review of Quality & Performance Report (Workforce)

Held on Monday 16 November 2020, 1pm – 2pm

VIA TEAMS

PRESENT:

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)
Adam Matthews	(AM)	Workforce Reconfiguration Lead
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Nikki Hosty	(NH)	Associate Director of Organisational Development (for agenda items 67/20 and 68/20)

59/20 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

60/20 **APOLOGIES FOR ABSENCE:**

Ellen Armistead, Deputy Chief Executive/Director of Nursing
Helen Barker, Chief Operating Officer
Jason Eddleston, Deputy director of Workforce and Organisational Development
Andrea McCourt, Company Secretary

61/20 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

62/20 **MINUTES OF MEETING HELD ON 19 OCTOBER 2020:**

The minutes of the Workforce Committee meeting held on 19 October 2020 were approved as a correct record.

63/20 **ACTION LOG**

The action log was reviewed and updated accordingly.

The Committee agreed the Recruitment Metrics report would be deferred to the December meeting.

64/20 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – OCTOBER 2020**

MB presented the report.

Summary
Performance on workforce metrics continues to be high and the Workforce domain increased to 84.8% in September 2020. This is now 17 consecutive months of a 'Green'

domain. Only 3 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Sickness Absence Rate' and 'Long term sickness absence rate'. The appraisal compliance for both medical and non-medical are not included in the Domain scoring due to postponement of appraisal season due and Covid-19 and will be included for non-medical at the end of the appraisal season.

Workforce – September 2020
Staff in Post increased by 31.26 FTE, which, due, in part, to 18.30 FTE leavers in September 2020. There has also been an increase of 5.73 FTE in the Establishment figure, along with student nurses leaving.
Turnover increased to 7.27% for the rolling 12 month period October 2019 to September 2020. This is a slight increase on the figure of 6.98% for August 2020.

Sickness absence – August 2020
The in-month sickness absence decreased to 3.67% in August 2020. The rolling 12 month rate decreased marginally for the eleventh consecutive time in 21 months, to 4.22%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 39.28% of sickness absence in August 2020, increasing from 38.57% in July 2020.

Sickness absence at 16 October 2020
Covid related: 1.96%
Non-covid related: 4.4%
Total = 6.3%

The RTW completion rate increased to 65.03% in August 2020.

Essential Safety Training – September 2020
Performance has improved in 7 of the core suite of essential safety training. With all 9 above the 90% target with 4 achieving the 95% 'stretch' target.
Overall compliance increased to 95.28% and is above the stretch target again following last month's decrease and is above the stretch target for the first time since July.

Workforce Spend – September 2020
Agency spend decreased by £0.03M, whilst bank spend increased by £0.5M.

Recruitment – September 2020
3 of the 5 recruitment metrics reported (Interview to Conditional offer, Pre employment to unconditional offer, and unconditional offer to acceptance) deteriorated in September 2020. The time for Unconditional offer to Acceptance in September 2020 decreased and was just over 3 weeks.

KH asked for an update on the health and wellbeing risk assessment. SD confirmed that 3390 risk assessments had been completed to date. A number of colleagues had submitted a form for the second time and analysis of the two is being undertaken. There has been a substantial increase of calls to the 24/7 helpline, users are predominantly colleagues who are being deployed again or still deployed from the first wave. SD added that some colleagues' personal circumstances is greatly affecting their mental health. The Committee noted a shorter production of the risk assessment form is being considered.

KH noted the reduction in agency and increase in bank use. SD advised that preference is to use bank staff as overall would have at least hospital knowledge and some experience that wouldn't add to the redeployment issue.

DS expressed her full support for the health and wellbeing hour acknowledging staffing challenges. SD reinforced the comments and reported there have been some great examples of use of the wellbeing hour and updates will be presented to Executive Board in

December and Board of Directors in January. DS confirmed her endorsement of the wellbeing hour can be shared with the Boards.

KH praised the overall positive figures under the current circumstances.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

65/20 **WORKFORCE COMMITTEE TERMS OF REFERENCE**

The current ToR had been circulated for review. AM had provided her comments on email which will be added to the document and shared with Committee members for comment/approval ahead of the next Committee meeting. The final version will be shared at the December meeting for sign off.

OUTCOME: The Committee **RECEIVED** the TOR and **AGREED** to the course of action.

66/20 **WORKFORCE COMMITTEE WORKPLAN**

The Committee reviewed the proposed 2020/2021 workplan and agreed the content.

OUTCOME: The Committee **RECEIVED** and **AGREED** the 2021 Committee Workplan.

67/20 **WORKFORCE RACE EQUALITY STANDARD (WRES)**
68/20 **WORKFORCE DISABILITY EQUALITY STANDARD (WDES)**

NH presented highlights of this year's data results and the 2020/2021 actions to deliver positive movement. Increased focus on virtual interaction and more on-line education awareness will reach a wider audience and enable colleagues the flexibility and accessibility at a time that suits them. The Trust's equality networks have been instrumental in the development of these action plans. The action plans will be monitored by the Inclusion Advisory Group on a bi-annual basis along with regular discussions at the Trust's Equality groups.

<u>WRES</u>

- Positive indicators were seen in the likelihood of BAME colleagues being appointed from shortlisting across all posts and colleagues believing that the Trust provides equal opportunities for career progression/promotion.

- The data showed an increase in the likelihood of BAME colleagues entering a formal disciplinary process. BAME colleagues experiencing harassment, bullying or abuse from both colleagues and patients/relatives/public has also increased along with BAME colleagues feeling discriminated at work.

In terms of disciplinary process, in 2021 a deep dive analysis will be undertaken of the past 2 years rolling data to understand cause/nature of the cases. KH asked if grievance cases were included in the results. NH explained that only disciplinary cases are part of the Standard data but the deep dive will capture all employee relations data.

DB noted an increase in both white and BAME colleagues experiencing bullying and harassment. NH advised this week is 'Anti-bullying week' and to support the promotional materials a 'say no to racism' campaign is being launched strengthened with direct messages about anti-racism and highlighting the consequences.

DS asked about the inclusive approach to recruitment panels. NH explained panel makeup will be scrutinised with confirmation that panel members have undertaken the unconscious bias module.

WDES

- Positive indicators were seen in the likelihood of disabled colleagues being appointed from shortlisting across all posts. An increase had been seen in colleagues believing the Trust provides equal opportunities for career progression/promotion. Less disabled colleagues said they felt pressure from their manager to come work and more disabled colleagues said they are satisfied with the extent to which their organisation values their work.

- The relative likelihood of disabled colleagues entering a formal capability process compared to non-disabled colleagues had increased. Disabled colleagues who said their employer had made adequate adjustments to enable them to carry out their work had decreased. The staff engagement score for disabled colleagues dropped marginally.

The committee noted the significant increase in the likelihood of both disabled and non-disabled colleagues entering a capability process. AM explained that from January 2019 a reporting change was implemented in ESR leading to the capture of all absence triggers.

DS asked what support is available for managers when considering reasonable adjustments. SD confirmed that managers should seek advice from their HR Business Partner. KH noted that the national staff survey results indicate a higher number of disabled colleagues in the Trust than actually recorded on ESR and acknowledged the efforts to tackle this.

OUTCOME: The Committee **RECEIVED** the data and **ENDORSED** the response to increase positive outcomes for colleagues.

69/20 **ANY OTHER BUSINESS**

SD reported CHFT's Staff Survey response rate is currently 46.5% - average across the region. At this point last year our response rate was 45.7%.

70/20 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

- Positive elements from WRES/WDES
- Good workforce performance
- Committee ToR
- Committee Workplan for 2020/2021

71/20 **DATE AND TIME OF NEXT MEETING:**

9 December 2020 (Deep Dive)
1pm – 3pm
Via Teams

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE – DEEP DIVE

Held on Wednesday 9 December 2020, 1pm – 2pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Andrea McCourt	(AMc)	Company Secretary
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Nikki Hosty	(NH)	FTSU/ED&I Manager	
Azizen Khan	(AK)	Assistant Director of Human Resources	
Adam Matthews	(AM)	Workforce Reconfiguration Lead	for agenda item 80/20
Charlotte North	(CN)	Assistant Director of Human Resources	
Rachael Pierce	(RP)	Recruitment Manager (for agenda items 77/20 and 78/20)	
Philip Lewer	(PL)	Chairman	
Owen Williams	(OW)	Chief Executive	

72/20 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

73/20 **APOLOGIES FOR ABSENCE:**

Ellen Armistead, Deputy Chief Executive/Director of Nursing
Helen Barker, Chief Operating Officer

74/20 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

75/20 **MINUTES OF MEETING HELD ON 16 NOVEMBER 2020:**

The minutes of the Workforce Committee meeting held on 16 November 2020 were approved as a correct record.

76/20 **ACTION LOG**

The action log was reviewed and updated accordingly.

77/20 **MATTERS ARISING**

Consultant Recruitment – Intranet Micro Site

RP provided a verbal update on the development of the micro site. The Committee noted the delay in the launch is attributed to the site developer Magpie furloughing its workforce between March and October this year. Magpie have since been provided with CHFT's material in order to build the website and are now on course for a go live date of end January 2021. The structure and language of the site is based on that of The Cupboard.

OUTCOME: The Committee **RECEIVED** and **NOTED** the position.

78/80 **RECRUITMENT KEY PERFORMANCE INDICATORS (KPIs)**

RP presented a paper which set out the Trust's recruitment KPIs and identified the improvements made to data reporting and compliance. The KPIs now align to the themes identified in the national NHS Enabling Staff Movement programme which looks to streamline employment processes to increase efficiency. Four out of five targets are attaining compliance. Pre-employment to unconditional offer is 2 days away from the target of 18 days primarily due to the lengthier recruitment process of doctors.

DS asked how delays in the vacancy control process were addressed. RP explained that changes had been implemented and improvements seen. Largely there is an issue around the number of authorisers required for one vacancy – in some areas 6 persons authorise one vacancy. JE reiterated that Trac creates full visibility of the overall recruitment process for every vacancy allowing recruitment colleagues to investigate data, identify blockages and respond where performance goes off.

DS understands that CHFT has a shorter notice period than other Trusts. RP wasn't aware of this but would ascertain the position and feedback to the Committee. JE referenced some time ago a piece was undertaken on notice periods and agreed to re-visit this.

KH asked if Trac offered flexibility for additional assessments eg psychometric testing. RP confirmed that additional processes can be incorporated and should be manageable within timescales.

Actions:

Compile an analysis of comparative employment contractual notice periods from other Trusts (CN).

Provide analysis on ED&I metrics (CN).

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

79/20 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – NOVEMBER 2020**

MB presented the report.

Summary

Performance on workforce metrics continues to be high and the Workforce domain decreased to 76.1% in October 2020. This is now 18 consecutive months of a 'Green' domain. 4 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)' and 'Short term sickness absence rate (rolling 12 month). Medical appraisals are hold due to the current Covid-19 pandemic and Non-medical compliance is excluded from the overall domain score following the postponement of the appraisal season until November to allow for all entries to be captured

Workforce – October 2020

The Staff in Post increased by 10.18 FTE, which, due, in part, to 0.61 FTE leavers in October 2020. There has also been an increase of 26.30 FTE in the Establishment figure, along with student nurses leaving.

Turnover decreased to 7.24% for the rolling 12 month period November 2019 to October 2020. This is a slight decrease on the figure of 7.27% for September 2020.

Sickness absence – September 2020
The in-month sickness absence increased to 4.08% in September 2020. The rolling 12 month rate increased marginally for the twelfth consecutive time in 22 months, to 4.24%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 35.08% of sickness absence in September 2020, decreasing from 39.28% in August 2020.

The return to work (RTW) completion rate decreased to 57.56% in September 2020.

Essential Safety Training – October 2020
Performance has improved in 5 of the core suite of essential safety training. With all 9 above the 90% target with 4 achieving the 95% 'stretch' target. Overall compliance increased to 95.51% and is above the stretch target again following last month's increase and is above the stretch target for the third time since July.

Workforce Spend – October 2020
Agency spend decreased by £0.03M. Bank spend also decreased by £0.3M.

Recruitment – October 2020
2 of the 5 recruitment metrics reported (Vacancy approval to advert placement and shortlisting to interview) deteriorated in October 2020. The time for Unconditional offer to Acceptance in October 2020 decreased and was just less than a week.

KH acknowledged the positive training position under the circumstances and also the increase in headcount. KH and DS stressed the importance of RTW discussions. AK advised a focussed piece of work is being undertaken to improve the position across the organisation.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

80/20 **COVID-19 RESPONSE TO OUR COLLEAGUES**

Colleagues from the Workforce & OD team presented on the workforce response to the pandemic.

Health & wellbeing
First wave reports suggested that BAME people were most at risk of harm from Covid. Our local data showed white men over 55 were more at risk so the approach to risk assess all our colleagues was taken. Colleagues reported increased anxiety levels and in response the Health and Wellbeing Risk Assessment was launched on 16 June. Response rate is 47.9%. Analysis of results and listening events identified specific areas for action.

KH asked if there were any actions to increase the response rate and how we benchmarked against other Trusts. NH advised that recruitment of Wellbeing Advisers is underway, the role will include providing dedicated onsite signposting to risk assessments. Additionally, funding has been approved for a BAME community engagement partner to support BAME wellbeing and promote the effectiveness of the risk assessment. AM reported consideration is being given to a streamlined risk assessment which focusses on physical assessment. AM advised it is not possible to compare against other Trusts as the national guidance states that if a risk assessment is offered to all colleagues, those who don't respond can be removed from the denominator and organisations can therefore report 100%. JE advised the practice taken across other trusts has been variable and confirmed CHFT has a robust approach.

Operational HR
First wave prompted deployment of staff quickly at a time when mechanisms were not in place. Key response was the introduction of a support package for deployed staff inclusive of an induction programme. 182 colleagues were deployed. Significant support provided to CV and CEV colleagues. Touchpoint sessions for colleagues introduced. Clinical Workforce Group established with a key role around the escalation, reset and stabilisation of the workforce.

Occupational Health
Immediately moved to a 7 day service, undertaking health and wellbeing assessments, telephone support and advice for colleagues; supporting test and trace activity; preparing for Covid-19 immunisation programme. Continued to deliver flu vaccinations (67% uptake currently). JE advised that a split between health & wellbeing and Occupational Health so that each has a different focus in terms of what they deliver is the likely future model of Occupational Health.

Recruitment
In the whole of 2019/2020, 705 applicants were recruited. This year to date 1266 applicants have been appointed. KH acknowledge the rapid response. Previous face to face processes moved to on-line and streamlining of retire and return process whilst ensuring safe employment processes. Change forms now issued via the recruitment team providing robust governance.

FWD
2 colleagues received Star Award for their response to the first wave. In second wave 374.83 posts filled per week. 3 Audits provided assurance of a robust employment checking process during this time. More collaborative working relationships forged and work with the Medical Workforce Covid planning response team. KH asked about rotas - if they could be gauged in real-time. CN advised that development of rotas has enabled the production of a daily dashboard.

Health & Wellbeing
Onset of the pandemic demonstrated an urgent need to strengthen wellbeing support. Wellbeing offer developed within 3 weeks of the pandemic underpinned by supporting line mangers and effective communication. Enhanced partnership with HR BPs and Occupational Health. External partners offered support to CHFT. Engagement of formal psychology service to enable rapid access to mental health support. Listening events for high intensity wards, friendly ear calls. Raised awareness of FTSU channel. Introduction of wellbeing hour. Data shows calls to the 24/7 helpline still increasing, from 15 December an external employee systems programme – Care First to be introduced. Going forward the requirement for robust Health and Wellbeing team. Two new wellbeing advisers to work with the Engagement Team. Funds secured for BAME business partner to encourage colleagues to access support available. Positive, satisfied feedback from colleagues referred to Socrates.

SD advised the response to workforce has shaped how we will look after our colleagues going forward. SD expressed great thanks to WOD colleagues for everything they have done to contribute to CHFT's overarching response. KH endorsed this and congratulated everyone involved.

OUTCOME: The Committee **NOTED** the valued work in response to the pandemic.

81/20 **IMPROVING PEOPLE PRACTICES**

JE presented a report which provides an assessment of our current practice against NHS Improvement (NHSI) recommendations and guidance to improve people practices based primarily on learning from a critical incident involving a London NHS Trust. The paper sets

out the actions implemented to ensure compliance with NHSI guidance. The Imperial College Trust has issued its revised disciplinary procedure, and this has been reviewed against the Trust's procedure and consideration is being given to assess if any adaptations need to be made.

DS felt the Trust had established a comprehensive response. DS asked what the training arrangements were for those providing support to individuals. JE confirmed guidance had been produced and work is progressing to ensure colleagues are able to undertake the role confidently.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the Trust's response.

82/20 **BOARD ASSURANCE FRAMEWORK (BAF)**

AMc presented the BAF workforce risks for Committee review.

The workforce risks will be reviewed within the full BAF at the Audit and Risk Committee on 26 January 2021 and the Board of Directors on 4 March 2021.

This third update of the financial year of the BAF will be reviewed by internal audit as part of its end of year Head of Internal Audit Opinion on internal controls which informs the 2020/21 annual report. Any of the risks and associated assurances overseen by this Committee will be potentially reviewed by Internal Audit as part of this review.

Four workforce risks present with a significant risk appetite. The Committee agreed there were no further risks to add in relation to 'Workforce fit for the future'.

The Committee reviewed and confirmed agreement of the risk appetite category for risk 12/19 colleague engagement. JE commented that the medical and nurse staffing risks had previously been discussed at Workforce Committee demonstrating an increase of staff but retained the score as it was acknowledged there are still pockets of pressure.

AMc advised that actions need to be identified to articulate mitigation of risk appetite between current and target for all four risks.

Action: Director risk leads to review response to mitigate to target risk appetite (SD).

OUTCOME: The Committee **RECEIVED** and **AGREED** the BAF.

83/20 **HOT HOUSE TOPICS TO DETERMINE**

Four Hot House dates have been scheduled for 2021.

Action: Provide long-list of Hot House topics (SD).

OUTCOME: The Committee **AGREED** to determine the Hot House topics at the next meeting.

84/20 **WORKFORCE COMMITTEE TERMS OF REFERENCE (ToR)**

The Committee noted that for the purpose of clarity some additions had been made to the ToR. The Committee agreed the revised ToR and these would be submitted to the January 2021 Board of Directors for ratification.

OUTCOME: The Committee **APPROVED** the Terms of Reference.

85/20 **WORKFORCE COMMITTEE ANNUAL REPORT 2019/2020**

This annual report describes the activities of the Workforce Committee between April 2019 and March 2020 and captures how the Committee met the duties within its Terms of Reference.

Attendance was noted as an issue. It was suggested that a 2021 forward plan is produced that incorporates Divisional and Executive participation at Committee meetings. In addition areas experiencing workforce challenges will be urged to escalate issues to the Committee.

Actions:

Develop action plan to respond to self-assessment outcome to target areas for improvement (JE). (AMc to provide an example).

Design 2021 plan focusing on Divisional/Executive Director participation (SD).

AMc reminded members that the 2020/2021 Committee annual report would need to be drawn up and agreed by July 2021.

OUTCOME: The Committee **AGREED** the annual report and **SUPPORTED** the proposals to improve attendance.

86/20 **2021 DATES OF WORKFORCE COMMITTEE**

Dates for next year's meetings had been shared with members.

OUTCOME: The Committee **NOTED** the dates.

87/20 **ANY OTHER BUSINESS**

The Chair asked what the final 2019 Staff Survey response rate was. SD confirmed 47% which compares well to other Trusts. The Committee noted 2018 survey response rate was 46%.

88/20 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Recruitment KPIs
RTW
EST
Sickness absence rates
Health & wellbeing risk assessment
TOR
Annual Report

The Chair thanked everyone for their enormous hard work and achievements during this year.

89/20 **DATE AND TIME OF NEXT MEETING:**

8 February 2021 (Deep Dive)
3pm – 5pm
Via Teams

Calderdale and Huddersfield NHS Charity

Minutes of the Charitable Funds Committee meeting held on Wednesday 25 November 2020, 2.00pm – 3.30pm via Microsoft Teams

PRESENT

Philip Lewer (PL)	Chair
Gary Boothby (GB)	Director of Finance
Richard Hopkin (RH)	Non-Executive Director
Sheila Taylor (ST)	Council of Governors' Representative

IN ATTENDANCE

Emma Kovaleski (EK)	Fundraising Manager
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Lyn Walsh (LW)	Finance Manager
Zoe Quarmby (ZQ)	ADF Financial Control
Badar Abbas (BA)	KPMG
Salma Younis (SY)	KPMG

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 and noted for Adele Roach, Ellen Armistead, David Birkenhead and Peter Wilkinson.

3. DRAFT LETTER OF REPRESENTATION

GB explained its purpose and the Committee agreed that it was happy for this to be signed on its behalf and sent to KPMG after the meeting.

ACTION: CH to arrange signed letter of representation to be sent to KPMG **25.11.20 - 1**.

4. DRAFT ANNUAL REPORT & ACCOUNTS 2019/20 (inc. Auditor's Report)

GB presented these and, subject to one slight amendment which is to add a further period of quarter 2 to the fund progress update for 2020/21, these were approved by the Committee. It was agreed that we would arrange signatures and sending to KPMG.

ACTION: CH to arrange signed Report & Accounts to be sent to KPMG **25.11.20 - 2**.

5. AUDIT HIGHLIGHTS MEMORANDUM 2020
SY and BA presented this on behalf of KPMG. BA said that KPMG is happy to issue an unqualified audit opinion and that there were no significant issues identified. No specific recommendations were made and he thanked the Charitable Funds Team for their cooperation and timely responses throughout the Audit. The Committee accepted this report and its findings and thanked BA and SY for the work done and the comprehensive way in which it was presented at this meeting.
SY and BA left the meeting at this point.

6. MINUTES OF MEETING HELD ON 26 AUGUST 2020
The minutes of the meeting held on 26 August 2020 were approved as an accurate record.

7. ACTION LOG AND MATTERS ARISING
EK gave an update on the action log and this was NOTED.

Risk Register
EK presented this and referred to an additional risk around fundraising that she had added. RH discussed including a risk related to fraud and was happy with EK's plans and response.
The Risk Register was NOTED. This is a live document which is reviewed at each meeting and then updated if necessary.

Terms of Reference of Ops Sub Committee and nominations
EK presented the list of (self) nominations and this was approved by the Committee, as was the final Terms of Reference which had earlier been approved outside of the meeting by some Committee members.
PL agreed to ask at the next meetings of Non Executive Directors and Council of Governors if anyone was interested in becoming a member of this sub committee.

ACTION: PL to ask if any interest at the next meetings of NEDs and Governors. **25.11.20 - 3**.

8. QTR 2 2020/21 INCOME & EXPENDITURE SUMMARY (inc. SOFA & BS)
EK presented the key points in this very comprehensive paper. Future opportunities were discussed and the contents were NOTED.

9. REVIEW OF INVESTMENT MANAGER
GB presented this paper. Its recommendation of remaining with CCLA for a further three years was accepted, with the proviso that three years was a maximum term and it could be reviewed after two years if it was established that there was an optimum time of year to move investments around. This would be decided after next month's meeting with CCLA.

10. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 28 SEPTEMBER 2020
The paper is for information only and its contents were NOTED.

11. THE GREAT GIFT APPEAL

EK gave an insight into all the different events taking place over the festive period, from receiving many donations of gifts via the Amazon Wish List, in particular for the Play Therapy Specialists, to pre-recorded messages for patients and staff from local sports teams and others in the community. She praised the efforts and willingness of our local community.

12. ANY OTHER BUSINESS

EK discussed the MRI Scanner/Radiology Enhancements proposal and fundraising appeal. The Committee was happy to approve this in principle and that the funds should come from the A Ormerod fund in the first instance but with all appeal proceeds to be put back into this fund, recognising that in the current climate there may be a shortfall. EK to provide all necessary documentation to allow set up of the approval, including CMG business case sign off. EK to construct a timeline regarding this appeal.

ACTION: EK to provide all documentation re approval set up. **25.11.20 - 4**.
ACTION: EK to construct appeal timeline. **25.11.20 – 5**.

DATE AND TIME OF NEXT MEETING:
Wednesday, 23 February 2021, 1.30pm – 3pm, via Microsoft Teams

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 21 October 2020 commencing at 10.00am via Microsoft Teams

PRESENT

Andy Nelson (AN)	Chair, Non-Executive Director
Richard Hopkin (RH)	Non-Executive Director
Denise Sterling (DS)	Non-Executive Director

IN ATTENDANCE

Andrea McCourt	Company Secretary
Gary Boothby	Director of Finance
Kirsty Archer	Deputy Director of Finance
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Kim Betts	Interim Internal Audit Manager, Audit Yorkshire
Salma Younis	Senior Manager, KPMG
Steve Moss	Anti-Crime Lead, Audit Yorkshire
John Richardson	Governor
Jackie Ryden	Corporate Governance Manager (minutes)
Philip Lewer	Chair of Calderdale and Huddersfield NHS Foundation Trust
Maxine Travis	Senior Risk Manager
Melanie Hill (Item 70/20)	Information Governance Manager
Mandy Hurley (Item 71/20)	Clinical Governance Audit Team Leader

66/20 APOLOGIES FOR ABSENCE

Apologies were received from Mandy Griffin, Clare Partridge and Marie Hall.

The Chair welcomed everyone to the Audit and Risk Committee meeting. Melanie Hill was attending to present the deep dive on Information Governance and Mandy Hurley was attending to respond to any queries regarding clinical audit.

67/20 DECLARATIONS OF INTEREST

The Chair reminded the Committee to declare any items of interest at any point in the agenda.

68/20 MINUTES OF THE MEETING HELD ON 22 JULY 2020

The minutes of the meeting held on 22 July 2020 were approved as a correct record subject to the following amendments.

Review of Losses and Special Payments
Hospital Pharmacy Services – should be corrected to Huddersfield Pharmacy Specials.

Review of Board Assurance Framework
The paragraph to be amended as below:
RH raised a number of queries relating to the proposed allocation of risks. He suggested that risk 3/20, Business Better Than Usual, might also need to be considered at the Transformation Programme Board. RH also pointed out that risk 2/20 Digital Strategy and Risk 6/20 Climate Action Failure should not be allocated to the Finance & Performance Committee ~~as there is no representation from the Health Informatics Team on the Finance & Performance Committee~~.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 22 July 2020 subject to the above amendments.

69/20 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updated accordingly.

OUTCOME: The Committee **NOTED** the updates to the Action Log.

70/20 INFORMATION GOVERNANCE DEEP DIVE

Melanie Hill, the Information Governance Manager, gave a presentation on Information Governance (IG) within CHFT including details on the Information Governance (IG) team, the Data Security and Protection Toolkit (DSPT), the Data Protection Impact Assessment (DPIA), the National Data Opt-Out (NDOO), incidents and the IG campaign, data security and protection training, policies and information asset owner work. The IG Team also provide IG services for a number of GP practices across Calderdale, Kirklees, Wakefield, Bradford, Leeds and for a variety of other organisations.

The DSP Toolkit is submitted on an annual basis, the submission date was extended this year from 31 March 2020 to 30 September 2020 due to the Covid pandemic. Every employee contributes to the DSPT in some way. 116 evidence items are required to be submitted; these fall into ten categories of evidence. This includes evidence of a target compliance with DSP training of 95% for the organisation. This contrasts with the Trust's overall target for essential skills training of 90%.

The Information Governance Manager advised that this year a 'Standards Not Met' Toolkit was submitted to NHS Digital with an improvement plan to address the areas that did not meet the standards required. Out of the 116 evidence items, four were not met: a) tracking of software assets; b) listing of unsupported software; c) patching; d) DSPT training. These are all addressed in the improvement plan. NHS Digital quickly updated the Trust's status to 'Standards Not Fully Met with a Plan Agreed'. They will monitor the improvement plan over the next 6-8 months prior to re-submission. A number of risks are associated with this and are logged on the risk register, which are reputational damage and risk of losing contracts due to non-compliance with the Toolkit. A further extension has been agreed to June 2021.

Data Protection Impact Assessments (DPIA) were introduced in June 2018 and must be completed by law at the start of every project or at the procurement stage; a shortened version of this has been introduced for the Covid period, and this will be re-visited once the pandemic quietens down.

The National Data Opt-Out was introduced in May 2018 with a compliance deadline of March 2020, now extended to 31 March 2021. This allows patients to opt out via NHS Digital of data being used for research and planning purposes. This is a requirement in the Toolkit. All necessary updates have been made and whole data uploads are currently being tested.

There have been a number of serious incidents recently related to inappropriate access of patient records. An IG awareness campaign is in hand, and an audit is being undertaken into access to 50 'deceased' patient records. There are severe consequences if a member of staff is found to have inappropriately accessed patient records. Three ICO reportable incidents occurred between April 2019 to September 2020, with no further action to be taken.

The Director of Finance asked how CHFT benchmarks against other Trusts, given that approximately £0.5m has been invested over the last 18 months on IG compliance. The Information Governance Manager confirmed that the Trust is in a better position than other organisations who are also having trouble meeting the standards. The team is confident that a 'standards met' Toolkit will be achieved at the next submission.

DS asked what measures could be put in place to address the shortfall in achieving the training target of 95%. The Information Governance Manager believes this may be linked to the fact that the overall training target set by the Trust is 90%. AM asked if there is an awareness across the Trust of the 5% discrepancy and suggested this should be discussed in other forums.

Following a query from the Company Secretary, the Information Governance Manager confirmed that the Information Governance and Records Strategy Group meetings are now scheduled following a gap during Covid and are back on track. This Group will review progress on the improvement plan on the Toolkit.

The Chair asked if the posters regarding the National Data Opt-Out had been tested. The Information Governance Manager agreed that this did not take place but will be re-addressed.

Following a query from the Chair, the Information Governance Manager advised that the teamwork with both the Information Asset Owners and Information Asset Administrators for collection of the necessary information and completion of the paperwork.

OUTCOME: The Committee **NOTED** the details provided in Information Governance Deep Dive presentation.

71/20 CLINICAL AUDIT PROGRAMME 2020/2021

Denise Sterling presented a six-month update on the 2020/2021 Clinical Audit programmes, supported by Mandy Hurley, Clinical Governance Team Leader. The Trust conducts four different categories of audit: national mandatory audits (Quality Accounts List), national non-mandatory audits, local priority audits e.g. NICE Clinical Guideline snapshot audits, Trust Quality Improvement projects etc. and local audit (service evaluations, self-interest).

The 2020/21 Trust Clinical Audit Programme includes a combination of the above projects. The clinical audit database is now up and running and all of the projects are included in the database. There have been significant changes over the last six months with the half day mandated governance meetings having been suspended which meant that clinicians have not been able to present the audits. These will now resume from November 2020.

The Clinical Audit Team has been working closely with Information Governance and Health Informatics to establish a standard operating procedure to ensure that robust systems and processes are in place.

The Clinical Governance Team Leader compared the quarter two figures with those achieved in quarter one and highlighted the improvements in the number of audits completed and audits that had not started. As at September 2020 a total of 353 local and national audits have been carried out across the Trust. There are a number of national audits which are still on the plan as these were put on hold or have not yet been published. An internal audit review of the clinical assurance process has just been

completed and an assurance level of significant was given with just eight minor or moderate recommendations.

RH asked if any benchmarking had been carried out on the programme and performance against other Trusts. The Clinical Governance Team Leader advised that this had not been done but comparisons are available as part of the CQC Insight reports and confirmed that she will forward the required information. The Clinical Governance Team Leader advised that the monthly CQC Insight report details the Trust figures for standards for national audits compared to national averages and will confirm whether the Trust is an outlier. Currently CHFT is an outlier for national breast cancer in older people, but is it is believed that this is related to reporting inconsistencies and this is being investigated.
Action: Mandy Hurley to send the most recent CQC Insight report to Jackie Ryden for dissemination with the minutes.

OUTCOME: The Committee **NOTED** the six month update on the Clinical Audit Programme 2020/2021.

72/20 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments

The Deputy Director of Finance presented a report summarising the losses and special payments for the quarter ending September 2020. The Deputy Director of Finance highlighted that overall the losses and special payments in the quarter is higher than average, and is specifically linked to Covid-19. Production by Huddersfield Pharmacy Specials (HPS) in support of elective work for other NHS organisations has impacted on its ability to move stock through the system which has impacted on losses and special payments.

Following a query from the Chair, the Deputy Director of Finance advised that HPS believe there is an opportunity to improve on this and make some progress.

RH queried the ex-gratia payments relating to complaints of £11,000 and asked what the process was to approve those payments. The Deputy Director of Finance confirmed that these payments are relatively rare, but she will follow this up and confirm details of the process. The Company Secretary advised that this could be related to payments recommended by the Parliamentary Health Service Ombudsman when a complaint is upheld.
Action: Deputy Director of Finance to confirm the process for approval of ex-gratia payments relating to complaints.

The Director of Finance expressed his concern about the significant impact on patients who lose personal effects -for hearing aids, glasses, earrings and clothing, (£4.4k) He added that this should be area to focus on and would like to see more awareness across the organisation.

OUTCOME: The Committee **APPROVED** the review of losses and special payments.

2. Review of Waiving of Standard Orders

The Deputy Director of Finance presented a report on the Trust's waiving of standing orders to enable volume and value to be monitored during the second financial quarter of 2020/21. This includes all orders placed as a result of single source tendering/quotations, and subject to completion and authorisation of the single source

approval form. In addition, it includes situations whereby non acceptance of the lowest tender has taken place within competitive tendering.

The Deputy Director of Finance highlighted the specific additional waivers being seen as a result of the pandemic. When the Standing Financial Instructions were revised in April 2020, it was noted that this would be an area there would be a greater need to exercise waivers; a full schedule of these items was included in the paper. In quarter one, the total of these exceptions was £8.25m of orders, of which £7.74m was above the tender limit, mostly related to personal protective equipment. In quarter two the value of these have reduced significantly to £560k. The vast majority of PPE is now received through national procurement.

The Deputy Director confirmed that following the discussion at the last meeting, a transparency notice has been issued by the Trust to effectively publish the information in a transparent way.

OUTCOME: The Committee **NOTED** the waiving of standing orders report.

3. Review of Emergency Amendments to Standing Financial Instructions (SFIs)

The Deputy Director of Finance advised that at the meeting of the Audit and Risk Committee in April 2020 it was agreed that the existing business as usual SFIs which were due for review would be extended for 6 months and a temporary emergency addendum to the policy would be applied to deal with the Covid-19 situation to allow for expedient decision making and investment in front line services whilst maintaining key controls.

From Month 7, October onwards a new national financial regime is in place. The Standing Financial Instructions have been amended in line with the new regime. At the start of the pandemic organisations were allowed to procure capital items of equipment to deal with the pandemic and receive reimbursement retrospectively. This process has now changed and in light of the changes in national guidance, whilst still recognising the need for expedient decision making, the emergency addendum to the SFIs has been reviewed and amended for Months 7 to 12.

The changes from the previous version are:

- Amendment to the wording of the temporary exception to SFI clause 3.2.2 re: Budgetary Delegation
- Removal of the temporary exception of SFI clause 12.1 re: Capital Investment

Similarly, there is no longer a retrospective process for revenue, but some flexibility has been left in place in recognition of a potential second wave.

OUTCOME: The Committee **APPROVED** the changes to the emergency addendum to the Standing Financial Instructions to deal with the management of Covid-19.

73/20 INTERNAL AUDIT

Internal Audit Quarter 2 Follow Up Report

The Internal Audit Manager provided details of the Trust-wide position on the implementation of internal audit recommendations which have fallen due in quarter two. Two recommendations remain outstanding relating to audits carried out in 2016/17 and 2017/18. The revised action date for Cyber Security has moved to January 2021. However, no revised date has been provided for the recommendation on consultant job plans.

Action: Internal Audit Manager to follow up on the outstanding recommendation for consultant job plans to ensure a revised date is provided.

The Internal Audit Manager pointed out that there is an error in the figures relating to the recommendations for audits undertaken in 2018/19 which she will investigate and report back to the Committee.

The recommendations that remain outstanding relate mainly to 2019/20 and reflect the impact of the pandemic on the implementation of the recommendations. These will be continued to be monitored and some of these will be reflected in new pieces of audit work. The details of all outstanding (overdue and not yet due) recommendations have been shared with the Executive Directors in order to review, assess and revise action dates, where appropriate.

The Director of Finance advised that he will be working with the Internal Audit Manager to review the discrepancies in the report regarding changes of date in order to ensure that there are no serious consequences resulting from dates being continually pushed back, and that new dates are provided and adhere to. The Chair welcomed this challenge.

RH asked if this related to any specific areas or across the Trust as a whole. The Director of Finance advised that these lie mainly with clinical colleagues, and some of them are 'must do' recommendations which are still required to be delivered despite the challenges of Covid-19.

Once the piece of work has been completed to identify the critical areas, the Director of Finance will discuss with the Chair to determine the next steps, with a view to inviting the leads to attend Audit and Risk Committee.

The Deputy Director of Finance pointed out support may be required for the leads to ensure the recommendations have clear and measurable actions.

Internal Audit Quarter 2 Progress Report

The Internal Audit Manager reported that there have been a number of audit reports with significant and high assurance. Six reports have been issued since July 2020 including the Clinical Audit report which will be presented to the Committee in January 2021. There has been one request for an addition to the plan for an audit on the health and well-being risk assessment. Work has already started on this as it was deemed to be urgent.

The plan is currently 30% complete in terms of the number of days, however much of the work will take place during quarter three and quarter four. Thirteen audits are underway which are expected to be completed by the end of the year, with a further three to start in November.

Audit Yorkshire has considered the Phase 3 Planning Letter and has completed a detailed piece of work on that to map against the plan. The Internal Audit Manager will meet with the Director of Finance to ensure this is included for both this year and next year.

Following a query from the Chair, the Internal Audit Manager advised that there are no concerns with the plan currently matching the Phase 3 letter and that an additional audit had been carried out on the Trust's response to Covid. The additional audit on health and well-being fits in well with the Phase 3 planning letter. The plan is achievable although there is some uncertainty around the audit on infection control or ward-based audits. The plan needs to be flexible this year.

OUTCOME: The Committee **APPROVED** the Internal Audit Quarter 2 Follow Up Report, the Internal Audit Progress Report and the Revised Internal Audit Plan and **RECEIVED** the Insight report for July to September 2020.

74/20 LOCAL COUNTER FRAUD PROGRESS REPORT

Steve Moss, the Head of Anti-Crime Services, Audit Yorkshire, presented the Counter Fraud Progress Report. He explained the recent changes in staff resource and that Adele Jowett will be assisting at the Trust for two days a week until a permanent arrangement has been agreed.

Since the last meeting in July 2020 a number of newsletters have been sent out covering a variety of topics and several fraud alerts have been issued.

Marie Hall has met with the Trust Fraud Champion, Andrea McCourt, to discuss how they will work together. The Head of Anti-Crime Services thanked Andrea for volunteering to take on this role.

Two fraud referrals have been made to the Counter Fraud team regarding fake sick notes and pharmacy sales. Enquiries are progressing and further details will be provided at the next meeting.

The new Government functional standards which were discussed at the last meeting were due to come into effect next year, but these have been brought forward and are coming into place now for compliance by the end of March 2021. Organisations are not expected to be fully compliant with all of them immediately and only 85% of them map across to the new standards. The implications for the Trust were detailed in the paper.

The Company Secretary asked if the deadline for the new standards might be expected to be extended to May given that the standards will not be known until February 2021. The Anti-Crime lead advised that this is not yet clear, but he will keep the Trust up to date with any further information.

The Trust participates in the National Fraud Initiative which is a sophisticated data matching exercise to match electronic data within and between participating bodies to prevent and detect fraudulent and erroneous payments from the public purse. The timetable of work for compliance was making staff aware their data is used as part of the exercise. The submission of the data is due to the Cabinet Office for analysis by 1 December 2020.

RH asked if the data matching deadline of 1 December 2020 can be met and the Head of Anti-Crime advised this should not be an issue.

The team are slightly behind on progress against the counter fraud plan but should be compliant by the end of March 2021.

Online training sessions have been developed which can be delivered by Microsoft Teams, and these have been advertised in the newsletters. The Chair asked if the online training will be promoted to ensure that it is completed. The Director of Finance advised that he will be picking this up with Adele Jowett to undertake some face to face training, and will raise the possibility of a virtual video training package which could be used by Audit Yorkshire across their whole client base. The Anti-Crime Lead would support this and advised that specific training packages have been produced already and will continue to be developed. The Deputy Director of Finance advised that the Leadership Development

Training includes a section on Managing our Money, with a section dedicated to counter fraud.

OUTCOME: The Committee **RECEIVED** the Local Counter Fraud Progress Report.

75/20 EXTERNAL AUDIT SECTOR UPDATE

Sector Update
The Senior Manager KPMG presented a report to highlight the main technical issues which are currently impacting on the health sector. The main point to flag up relates to the revision to value for money reporting arrangements. This consultation is now closed and official guidance on the work programme is awaited. A summary of the key areas where changes will occur was set out in the report. Once details have been issued and confirmed, KPMG will provide further detail on the extent of required procedures and the expected reporting and will agree with management the timescales and approach for completing the required risk assessments ahead of preparing the audit plan.

The Senior Manager KPMG also highlighted the revision to ISA570 which requires that organisations have undertaken an assessment of their ability to continue as a going concern, assessed risks to their continued status as a going concern and identified actions required in response to those risks. KPMG will work with management to consider the impact of the revised ISA and what changes may be required.

OUTCOME: The Committee **RECEIVED** the sector update.

76/20 COMPANY SECRETARY'S BUSINESS

The annual workplan for the Audit and Risk Committee for 2021 was circulated for consideration for the current meeting and the following twelve months subject to any change in national guidance.

The Company Secretary advised that deep dives have been scheduled for each meeting together with the health and safety risk owned by the Committee (risk 16/19).

An external audit re-tender exercise will be required and needs to be discussed with the Council of Governors. RH queried the timing of the re-tender exercise and the Company Secretary advised that she understood that this needs to be completed by the end of the financial year, but she will confirm the timescale outside of the meeting with the Director of Finance. The Director of Finance confirmed that KPMG is in place as external auditor for the financial year 2020/21 following the previous extension approved by the Audit and Risk Committee. He added that during a recent meeting of the Audit Yorkshire Board a number of organisations flagged current challenges in getting companies to bid for external audit work in the NHS.

OUTCOME: The Committee **APPROVED** the Annual Workplan for the Audit and Risk Committee for 2021 subject to confirmation of the timing of the re-tender exercise and external audit plan and fees.

77/20 REVIEW OF HEALTH AND SAFETY RISK

The Company Secretary presented an update to the Board Assurance Framework (BAF) Health and Safety risk, risk 16/19, for which the Audit and Risk Committee is the responsible Board Committee in terms of assurance, prior to review at the Trust Board on 5 November 2020. A deep dive on health and safety was presented to the Committee in July 2020, and two updates have been provided to the Board.

Updates on the risk have been provided by the Director of Workforce and Organisational Development. The new Head of Health and Safety, Richard Hill, will take forward any actions to address gaps. The Chair confirmed that the risk update was complete and was pleased to see the third-party piece included in the risk. There will be a third health and safety update to the Board in January 2021.

OUTCOME: The Committee **NOTED** the update to the Health and Safety Risk 16/19 and **APPROVED** its presentation to Board on 5 November 2020 as part of the Board Assurance Framework.

78/20 REVIEW OF BOARD ASSURANCE FRAMEWORK

The Company Secretary presented an update on the processes for review of the Board Assurance Framework (BAF) and the second update on the BAF to the Committee for review and approval prior to review at the Trust Board on 5 November 2020.

The risks for review by each Board Committee and review process were summarised with a proposed change to risk 9/19 to be the sole responsibility of the Joint Liaison Committee reporting to the Finance and Performance Committee.

Given the significant movement in the BAF in the report to the Committee on 22 July 2020, there are no new risks and no changes to risk scores to report from this second update. The main changes relate to the gaps in controls and assurances.

All risks have been updated by the lead Director during October 2020 and are highlighted in the report. There are a total of 21 risks on the BAF, six with risk exposure, three of which are within the remit of the Finance and Performance Committee and three within the remit of the Board.

Risk 5/19, EPR benefits realisation, has been removed following agreement at the Board meeting on 3 September 2020, as previously supported by the Committee.

Following discussions with the Director of Finance, the Managing Director of Calderdale and Huddersfield Solutions and the Director of Nursing and it has been agreed that risk 9.19 Estates will be discussed further to allow for wider engagement but this will be owned by the Joint Liaison Committee solely.

RH advised that risk 8/19 national and local performance has already been discussed at the Finance and Performance committee meeting on 1 September 2020. He further advised that the risk appetite for risk 18/19 long term financial sustainability has been reduced from 25 to 16. The Company Secretary will make the necessary amendments prior to submission to the Board.

The chair was pleased to see that the process of delegation to sub-committees is working well, and RH and DS agreed with this. The Chair stated the management and assurances of risks looks more complete but there is still some work to be done on the quality of information, in particular the gaps and actions. The Chair will pick this up with the Company Secretary outside of the meeting prior to submission to Board.

OUTCOME: The Committee **NOTED** the progress with Board Committee reviews of the Board Assurance Frameworks risks and the change of Committee review for risk 9/19 Estates, **NOTED** the updates to the Board Assurance Framework, and **RECOMMENDED** the Board Assurance Framework to the Board of Directors for approval on 5 November 2020 subject to the above amendments.

79/20 DECLARATION OF INTERESTS

The Company Secretary provided an update on the declarations compliance for the financial year 2019/2020 for those members of staff classed as decision makers (Band 7 and above). This report was deferred from the April Committee meeting as the reminder to complete the declarations was postponed due to the pandemic.

The analysis shows that out of the 993 decision makers, 53% have submitted a declaration. The majority were nil declarations. There is a process issue to be resolved regarding the submission of nil declarations during the year. Outside of this, the main declarations relate to clinical private practice and outside employment. There is more work to be done in terms of raising awareness but submission of declarations has been included in the performance appraisal process this year. There are some capacity issues related to queries regarding the system. A communications strategy is to be implemented which will also remind staff that declarations must be made annually.

The Director of Finance expressed his disappointment at the low rate of compliance. He has discussed this with the Director of Workforce and Organisational Development in light of the fact that compliance is linked to the appraisal system and progression through the increment gateway. He has suggested that discussions are taken to a different forum to decide on whether further action is taken for non-compliance.

The Company Secretary thanked Jackie Ryden for pulling this new report together and advised that there is no comparable data to benchmark this against. The Senior Manager KPMG stated that the level of compliance is similar to that seen in other Trusts and engagement of staff is a challenge. As the appraisal process ends in October 2020, the Director of Finance asked if it would be possible to repeat the data exercise in November 2020 to see if compliance has improved. The Company Secretary suggested that a reminder is sent out to colleagues in the Newsletter prior to this. The Director of Finance advised that this could be raised in the weekly Executive Directors Forum.
Action: The Company Secretary/Corporate Governance Manager to re-run the report in November 2020 to identify where the gaps are and raise in the weekly Executive Directors Forum.

OUTCOME: The Committee **NOTED** the position of 53% compliance with the end of year declarations for 2019/2020 and **NOTED** the work being undertaken to focus on improving compliance for the financial year 2020/2021.

80/20 SUMMARY REPORTS AND MINUTES TO RECEIVE

A summary report of work undertaken since August 2020 was provided for the following groups:

- Risk Group (Formerly Risk and Compliance Group)
  The Senior Risk Manager advised that the compliance elements of the former Risk and Compliance Group will be picked up by the CQC Response Group. The Terms of Reference have been reviewed and will be submitted to a future Audit and Risk Committee. The Risk Group will focus on deep dives and better scrutiny and challenge of high level risks.
- Information Governance and Records Strategy Group – no questions were raised.
- Health and Safety Committee
  RH referred to the ligature policy and action plan and asked if this is being progressed and receiving the right level of attention. The Senior Risk Manager advised that a number of serious incidents have involved ligatures and that it is high on the agenda

for the Mental Health Group and the Health and Safety Group. Learning from serious incidents is incorporated into the ligature policy and an action plan is in place to address the issues. The Company Secretary asked if it has been decided who is to be the policy lead for the ligature policy, and the Senior Risk Manager advised this has not been confirmed.

- The Chair asked if the issue mentioned relating to medical gas is similar to the oxygen never events. The Senior Risk Manager was not clear but will look into this and report back.
  Action: Senior Risk Manager to clarify the issue relating to medical gas.
- Data Quality Board – no questions were raised.

Minutes of the above meetings were provided for assurance and were available in the Review Room on Convene and circulated to attendees of the Audit and Risk Committee with the agenda.

OUTCOME: The Committee **NOTED** the summary reports for the Risk Group, the Information Governance and Records Strategy Group, the Health and Safety Committee and the Data Quality Board.

81/20 ANY OTHER BUSINESS

There was no other business.

82/20 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Information Governance Group – training compliance issue with the DSP Toolkit of 95% compared to 90% for Essential Skills Training overall.
- Clinical audit – need to be constantly aware of the challenges Covid poses to completion of the audits.
- Internal audit – Potential impact of Covid on completion of the audits.
- BAF – to be recommended for approval to the Board.

83/20 DATE AND TIME OF THE NEXT MEETING

Tuesday 26 January 2021
10.00am – 12.15pm

84/20 REVIEW OF MEETING

The meeting ran well with increased time allowed for clinical audit and the deep dive.

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Monday 2 November 2020, 11.00am – 1.00pm Via Microsoft Teams

PRESENT

Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director (CHAIR)
Peter Wilkinson	Non-Executive Director
Owen Williams	Chief Executive

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Christopher Roberts	General Manager, Integrated Medical Specialties (In part)
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Stephen Baines	Governor Observer
Stuart Baron	Associate Director of Finance

ITEM

132/20 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

133/20 APOLOGIES FOR ABSENCE

Apologies were received and noted for Helen Barker.

134/20 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

135/20 MINUTES OF THE MEETING HELD 28 SEPTEMBER 2020

The Minutes of the Public meeting held 28 September 2020 were approved as an accurate record.

136/20 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed and noted.

009/19: Use of Resources Update (UOR) – The Deputy Director of Finance provided the Committee with the progress to date and the next steps to be considered, highlighting the following key points: -

- Work has progressed through the groups for each of the five key lines of enquiry. The summary slide set is to be finalised for each group and reviewed through a peer to peer session with representation from each area to be scheduled in Quarter 3.
- Information has been sought with regard to plans for recommencing UOR assessments in terms of timescale or any changes to metrics in recognition of COVID.
- A quarterly refresh of evidence will be planned in order to keep the information live, recognising that COVID will significantly impact many metrics.

- Progressing to the stage of external review will be revisited post the peer to peer review in the context of the changing metrics and as greater clarity is received on reset of the CQC/UOR inspection process.

Discussions took place regarding the merits of an external review and the Committee supported an option to approach the ICS who may have some resource. It was agreed that the Director of Finance and Deputy Director of Finance would consider options for an external review.

The Director of Finance also mentioned that our overall UOR score within the Finance Report has deteriorated, this was linked to one score based on the Capital Service Cover. The score has deteriorated based on the revised debt regime and conversion of historic debt into Public Dividend Capital. This makes it impossible for the Trust to improve its overall score, despite improvements in other metrics. It was noted that discussions have taken place with other organisations and NHSI to try to determine how the UOR score should be declared going forward. It was noted that NHSI are not reviewing this metric in 2020/21 and other organisations are no longer reporting their score. The thoughts of the Committee were shared, and it was agreed that the reporting of UOR in relation to the Finance Reports and BAF Risks should be considered off-line.

ACTION: To consider the option for an external review by the ICS of our Use of Resources preparation – **GB/KA**

ACTION: To consider off-line how the Finance Reports and BAF Risks should report the UOR score – **GB/KA**

The Committee **NOTED** the positive progress made by the groups and supported the next steps outlined within the paper.

052/20: Review Divisional Performance – The Chair reminded the Committee that this item had been discussed as part of the Budget Book analysis earlier in the year, and that within that document there had been details of the Income and Contribution by Division. The Director of Finance verbally reported to the Committee that there had not been any movement in budgets between Divisions throughout COVID. The Chair requested that it would be interesting to understand the cost allocations behind the Divisional contributions and that this should be looked at in conjunction when preparing for next year's budget.

ACTION: To schedule on the Work Plan a review at the end of the financial year 2020/21 – **BS scheduled for April 2021 – action closed.**

FINANCE & PERFORMANCE

137/20 INTEGRATED PERFORMANCE REVIEW – SEPTEMBER 2020

The Assistant Director of Performance reported an improved position on the previous 3 months of 72%. It was noted that the improvement has been due to some key indicators coming back in line such as Summary Hospital-level Mortality Indicator (SHMI) which is back below 100 (COVID patients have been excluded nationally), short-term sickness is back to GREEN, return to work interviews improved plus Finance borrowing has improved.

It was also noted that there are issues still on-going around Diagnostics 6 week waits, ASIs and 52 week waits. In addition, 3 of the stroke indicators are now below target.

It was noted that moving forward a narrative will be reported against our key indicators, stroke is a key indicator, and this will be monitored month on month to review progress. It was also noted that out of 6 domains, 5 had seen improvement with Caring being the only domain which remained static and teams are working closely to look at the quality priorities.

Discussions took place regarding the sickness absence and the COVID and non-COVID split. It was noted that COVID absence has increased but still appears lower than what is happening in other Trusts within West Yorkshire.

ACTION: To pick up with the Workforce Team to address the sickness statistics regarding COVID and non-COVID absence - **PK**

Post-Meeting Note: Having queried the sickness table with Workforce they confirmed there had been an error and the report was amended accordingly – the COVID related absence was 1.9% / Non-COVID absence 4.4% / Total absence 6.3%

138/20 STROKE DEEP-DIVE

The Assistant Director of Performance introduced the paper which was to provide Finance & Performance Committee with the results of the Audit of % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival. Stroke is one of the key indicators which has never been achieved.

Chris Roberts the General Manager for Integrated Medical Specialties presented the information with which Jackie Wilkinson, Senior Nurse for Stroke, had been particularly involved. It was noted that the current year to date percentage at the end of September being reported against a target of 90% is 65% with monthly performance ranging from 72% in May down to 51% in September which is a real cause for concern.

It was also noted that in the last 6 months (April to September 2020) there have been 118 breaches of which the following are the key areas: -

- The number of 'No beds' on ASU = 25% of all breaches
- Late diagnostics = 19% of all breaches
- Not breaches = 13% of all breaches
- Late referral = 14% of all breaches

In terms of recommendations and actions, the following were highlighted: -

1. Review use of (ESD) Early Supportive Discharge team to ensure timely discharges to maximise capacity utilisation
2. Further analysis into medical outliers and consider protection of bed base for stroke patients only
3. Establish early stroke input into patients presenting with dizziness, falls, confusion and headache as these are the patients receiving late diagnosis
4. Data validation prior to submission to prevent reporting errors. It was noted that when patients are being treated in the stroke assessment bed in ED at

CRH, this has not been documented accordingly, this is now being addressed.

5. Development of improved stroke pathway from HRI (23% of all breaches) supported by stroke telemed review, improved CT access and YAS transfer to CRH, this is already being progressed and final barriers to implementation are being discussed.
6. Stroke assessment bed (SAB) open 24/7 instead of Mon-Fri 08.00-17.00 at CRH and HRI
7. MAU to triage all potential strokes referred direct from GP and redirect to CRH ED

It was noted that the Committee were very impressed with the quality and detail of the Equality Impact Assessment (EQIA) which had been carried out as part of the report.

It was asked if COVID had had any effect on the diversion from our targets. It was noted that the following are the key areas which have impacted on our performance over the last 6 to 7 months. Firstly, the stroke assessment beds had been stood down and the beds used flexibly for a period during COVID as were the beds on the Stroke ward. Secondly, how we manage rehabilitation for patients also has had an impact on bed capacity and this continues to be discussed internally and with external partners.

It was also noted that the in-month score for 'Access to CT' within an hour had dipped. It was acknowledged that this is a key criteria for outcomes and that during the COVID period, cleaning has added to the challenge. However, in addition, there had not been an agreement in place at HRI for patients to have their CT scan carried out within an hour, this agreement is now in place with Radiology.

It was agreed that to be able to monitor any improvement, timelines need to be placed against the actions. It was also acknowledged that to achieve the national target of 90% would be unrealistic and that to get back to the 70+% should be achievable bearing in mind COVID.

It was noted that two of our stroke consultants are due to retire next year, which is a risk for the organisation, however, we are planning sustainably for this and will be advertising shortly.

ACTION: To provide timelines against the key actions prior to the next meeting to enable the Committee to decide when to re-visit as part of the IPR – **CR/PK, 30/11/20**

On behalf of the Committee the Chair thanked CR for a very useful summary. The Committee **NOTED** the recommendations and actions.

139/20 MONTH 6 FINANCE REPORT

The Director of Finance reported that Month 6 shows a breakeven position based on receipt of top-up payments of circa £14m. The Trust has incurred costs of £16.28m in relation to COVID and in terms of COVID funding all bids to the end of Month 5 have been paid, with a further £2.38m required for Month 6. The Director of Finance

also reported that an Internal Audit report into what has been 'badged' as COVID costs had been carried out with a positive outcome.

It was noted that there is a small risk to the financial position with regard to the achievement of the elective incentive scheme, which was to start in September. This was an incentive for organisations to deliver the same level of activity that was delivered 12 months previously, any organisation that did not achieve the same level of activity would lose an element of income from their top up. The value of risk is £440k.

It was also noted that the cash balance was higher than planned and the Public Sector Payment Policy score continues to improve. Agency is still below trajectory and £2m of CIP has been delivered against a £7.4m plan year to date.

Phase 3 Re-set Plan Update – The Director of Finance updated the Committee regarding a request for an extra 301 wte posts to deliver the re-set plan. It was noted that further discussions had taken place with 265 wte posts being supported, the vast majority required to make sure there are sufficient staff in areas to protect patients and staff. It was noted that the in-year cost would be £6.3m which is included in the forecast to the end of the year.

In terms of the overall financial forecast and submission, the ICS has been given a funding allocation, there was a significant gap, however the gap has been reduced based on the clarity around the rules. It was noted that the ICS submitted a plan with a gap of £63m, this includes a £23m technical accounting issue, £26m relating to 'Other' income across the ICS and £14m worth of known issues relating to the way that funding has been allocated.

As reported in the Financial Report, CHFT have submitted a plan with a £24.9m gap which relates to the technical accounting issues of £23m, £1.6m gap on 'other' income and other items making up the balance.

Discussions took place regarding staffing and the financial challenge acknowledging the ever moving COVID situation.

ACTION: To provide a paper to the Committee clarifying the staffing assumptions and the requirement to cover Phase 3 / COVID 2nd Wave – **GB, 30/11/20**

THIS/PMU Income & Expenditure – The Director of Finance confirmed that THIS are forecasting to over-deliver due to NPex (CHFT host servers for Pathology across the region). HPS will be below their plan primarily due to a reduction in elective activity.

High-Level Risks – The Committee noted and discussed the risks within the Finance Report, it was agreed that the scores should remain unchanged.

The Committee **NOTED** the Month 6 Finance Report.

GOVERNANCE

140/20 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were received by the Committee:

- Draft Minutes from the CHFT/CHS Joint Liaison Committee held 7 October 2020

- Draft Minutes from the Commercial Investment & Strategy Committee held 24 September 2020
- Draft Minutes from the Capital Planning Group held 13 October 2020
- C&GH A&E Delivery Board held 13 October 2020
- Draft Minutes from the Cash Committee held 14 October 2020
    - It was noted that regarding the aged debt balance it was emphasised that the total is suppressed as there is a £0.5m credit to a CCG included. If the credit is excluded the debt would stand at £3.8m not £3.3m

It was agreed that the summaries provided with the Minutes are helpful when reviewing.

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

141/20 WORK PLAN 2020/21

The Work Plan was discussed with the following points highlighted:

- Due to review the Commercial Strategy 30 November 2020
- Review BAF Risks – to schedule a date for March 2021
- IPR Outcome Based Indicators to review January 2021

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

142/20 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board: -

- Stroke deep-dive – we are still quite away from the 90% target, however, the key issues have been identified with an action plan in place, timelines will be added to ensure that these can be monitored going forward.
- IPR – much improved position in month, however, there are still certain areas under review e.g. SHIMI and HSMR. Issues with diagnostics and ASIs. Sickness absence – clarification required between the split of COVID and Non-COVID absence.
- UoR Update – plan to carry out a peer to peer review of the various working groups, a further update to the Committee is expected within the October to December quarter. We are still looking at options for an external review to take place in the following quarter. Discussions are taking place around the UoR score and how this should be declared going forward particularly with regard to the Capital Service Cover.
- Month 6 - YTD reported break-even after top-up payments of £14m and COVID costs of £16.3m. Cash balance is slightly above £59m. Forecast submitted at ICS level with a gap of £63m, which has been identified. CHFT had a gap of £24.9m, of which the technical accounting point was £23m, other income £1.6m, other items making up the balance.
- Re-set Plan – discussions took place around the recruitment assumptions element of the revised plan and a detailed paper will come to the next meeting for consideration.
- High-level Risks – were discussed but remain unchanged at the current time.

143/20 REVIEW OF MEETING

There were no points to note.

144/20 ANY OTHER BUSINESS

Project Echo – The Associate Director of Finance updated that the regional NHSI Finance Team had had a briefing with finance colleagues at a national level and it was agreed that the business case should go to their Joint Investment Committee on the 23 November 2020. SB will liaise with them to confirm that this is an agenda item and offer support to provide any documents required for that meeting.

DATE AND TIME OF NEXT MEETING:
Monday 30 November 2020, 11am – 1pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Monday 30 November 2020, 11.00am – 1.00pm Via Microsoft Teams

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Chief Operating Officer
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director (CHAIR)
Owen Williams	Chief Executive

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Philip Lewer	Chair
Stuart Baron	Associate Director of Finance
Rhianna Lomas	Finance Secretary - Observing

ITEM

145/20 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting and acknowledged Rhianna Lomas who was observing the meeting.

146/20 APOLOGIES FOR ABSENCE

Apologies were received and noted for Peter Wilkinson and Stephen Baines

147/20 DECLARATIONS OF INTEREST

Declarations of Interest were noted for Stuart Baron as a Director of CHS for item 152/20 on the Agenda.

148/20 MINUTES OF THE MEETING HELD 2 NOVEMBER 2020

The Minutes of the Public meeting held 2 November 2020 were approved as an accurate record following the addition of Peter Wilkinson, Non-Executive as an attendee.

149/20 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed as follows:

115/20: Business Better Than Usual (BBTU) – The Director of Transformation & Partnerships updated the Committee that out of 12 themes, 11 had completed their templates outlining their ambitions and key objectives. Meetings with theme leads are being carried out this week with the aim of presenting to the Transformation Board on the 14 December 2020. Thereafter outcomes will be shared with Quality Committee and Finance & Performance Committee in either January or February. It was agreed that this item would stay on the Action Log as a reminder.

138/20: Stroke Deep-Dive – The Assistant Director of Performance updated the Committee regarding the timelines which were requested against the actions outlined at the last meeting.

The following update was received for the three key areas of action:-

1. **Data validation prior to submission to prevent reporting errors** – there are now additional notes in patient records to ensure the patient is recognised as being in a stroke bed.
2. **Development of improved stroke pathway** at HRI – the pathway is now agreed with the stroke Consultants who are ready to implement mid-December. There has been additional agreement with radiology that all stroke patients are scanned within 1 hour.
3. **Stroke assessment bed** (SAB) open 24/7 – staff have been identified and the implementation date is to be agreed with the ED as currently the bed is being used flexibly to accommodate COVID patients.

It was noted that further work is required to complete all the actions and the this will be shared with the Committee off-line.

The Chief Operating Officer added that the key element is for the organisation to deliver a Community Model as there is a difference in options regarding the risk profile for the patient moving out of the hospital setting and having therapy at home. It was noted that we are trying to work through this internally and with the CCG Commissioning Team and Locala. It was suggested that this element should come back to Committee in the New Year.

ACTION: The complete set of timelines will be shared off-line for discussion at the next meeting – **PK, 13/12/20**

ACTION: The Community Model element of Stroke to be scheduled on the Work Plan for review in the New Year – **HB/PK, date to be confirmed.**

FINANCE & PERFORMANCE

150/20 MONTH 7 FINANCE REPORT

The Director of Finance reported that Month 7 was the first month of reporting following submission of our plan and that we are no longer on a retrospective top-up. It was noted that whilst activity had been delivered Pay costs are £1.00m below the planned level year to date due to some slippage on recruitment to the additional approved posts required to deliver Phase 3 activity plans and the timing of implementation of new nursing rotas. In addition, the in-month improvement and some further slippage on recruitment should offset the unidentified place-based gap of £1.4m that was assumed to be delivered in the Trust's plan.

It was also noted that the funding for a vaccination scheme will be discussed at a Webinar later today, however, based on frequently asked questions the funding allocation will be given to the ICS to support the scheme.

RH asked about the background in relation to the significant variances within diagnostic imaging and testing which in month is 66% above plan. The Deputy Director of Finance would look into the query, however, the Director of Finance suggested that this could increases in relatively low-cost pathology tests rather than more resource in expensive Radiology examinations.

With regard to the Use of Resources metric, it was noted that we have decided to take a less conservative approach following conversations with NHSI and this will be the position which will be seen going forward. The figure we report has been adjusted to ignore the impact of the debt conversion to PDC and more accurately reflects performance.

ACTION: To provide an answer to the query regarding variances within diagnostics – **KA, asap**

The Committee **NOTED** the Month 7 Finance Report.

151/20 PHASE 3 ADDITIONAL STAFFING

The Director of Finance reminded the Committee of discussions held at the last meeting. It was noted that a paper has been drafted but is still incomplete, however, at the moment it shows that at Month 7, whilst we increased the establishment in the latest plan by almost 265, very few of those posts have been appointed to. It was also noted that within the paper we are trying to understand the likelihood of appointing staff, if not, how are we mitigating risks. The draft paper shows that the establishment of an extra 130 qualified nurses increased but that this has only increased our vacancies by 130, which is reflected in the Month 7 financial position where we are underspent significantly and we have also seen an increase in requests for bank and agency staff, however, the uptake has not increased. In addition, due to COVID to the end of Month 7 and throughout November we have cancelled various elective and outpatient activity and around 109 wte have been redeployed out of those areas into qualified nurse vacancies.

In summary, from a finance modelling point of view, we need to look further at the impact of non-recruitment to these posts.

The Chief Operating Officer acknowledged that prior to the paper being finalised there needs to be further understanding of our normal planned work and understanding where this is reflective of different models of working.

ACTION: Following further internal discussions a draft paper will be circulated to Finance & Performance Committee members – **GB, prior to the next meeting.**

152/20 FISCAL ARRANGEMENTS BETWEEN CHFT AND CALDERDALE AND HUDDERSFIELD SOLUTIONS (CHS)

The Deputy Director of Finance reported that the Trust's subsidiary company has been operating successfully for two years and has delivered a profit in each reported year. CHS has been able to work with the Trust very responsively through the challenges of COVID in 20/21. Effort is now focussed on further strengthening the formal sign off on contract variations and raising awareness of the cross-charging process with operational colleagues and divisions.

It was noted that the fiscal arrangements to manage CHS as part of the Trust group add a significant layer of transactional complexity. The most significant complexity is driven by the VAT accounting arrangements. The proposed national reforms to the VAT regime could lessen this burden but equally risk the loss of a differentiated saving to those Trusts with subsidiary companies and a potential pressure to CHFT through a reduction in funding.

SB also highlighted that in addition to the benefits recognised, from a capital perspective, HRI investments are planned on a VAT neutral basis and this allows a significant saving on capital spend which could then be invested in medical equipment or in any other key areas.

RH asked if there are any obvious solutions regarding the streamlining of the complexities, it was noted that the process has been reviewed internally by several colleagues with no obvious outcomes. It was acknowledged that experience has made a difference, however, the volume of data and intricacies involved makes it very entangled. We also have additional external VAT support from EY and they have not offered any solution.

The Committee **NOTED** the contents of the paper.

153/20 BENCHMARKING NETWORK REVIEW

The Deputy Director of Finance explained that the reports included in the papers were produced by the NHS Benchmarking Network and provides an analysis of the 2018/19 NHSI National Cost Collection. The opportunities highlighted by the Benchmarking Network report accord with those previously identified by the Trust through its own analysis.

The report highlights an overall savings opportunity of £64.8m for CHFT. It was noted that this scale should be viewed with caution as this represents the total of all of the areas where the Trust has costs above the national average but does not take into account those areas where costs are below average. In some instances, a number of closely linked services need to be viewed in tandem as one area has lower than expected costs whilst another shows potential savings, however, this is simply down to differences in service models or cost attribution between different Trusts. By far the most material of these is Non-Elective Inpatients with a potential saving of £33.0m. It was noted that several significant steps have been taken to address this including the Safer CIP scheme, resulting in improved patient flow, length of stay and reduced bed numbers. This has been complemented by the actions taken to reduce agency expenditure from a peak of £23.3m in 2016/17 to £7.1m in 2019/20.

The Deputy Director of Finance reminded the Committee that the analysis is based on historic 2018/19 reference costs as these were the latest published results, service changes enacted and CIP in 2019/20 will therefore not be reflected. Equally, this represents a business as usual model in a pre Covid-19 environment

The Deputy Director of Finance went on to describe other areas of opportunity, as per the report.

Discussions took place regarding the findings of the report including a discussion around the practicalities of a possible reconciliation and a detailed assessment of the £33m potential Non-Elective Inpatient saving. RH acknowledged all comments, however, he still felt slightly uncomfortable not being able to reconcile this saving.

The Deputy Director of Finance highlighted that the comparisons are not perfect and specific actions have been taken focussing on these areas of savings opportunity. There remains a level of cost pressure featured here which is structurally driven which cannot be reversed in the immediate term.

It was suggested and agreed that further discussions would be taken off-line to establish what would be required to provide assurance to the Chair of the Committee.

In terms of addressing future CIP arrangements, it was noted that the Director of Finance had been asked to look at the work which is being progressed by Leeds Teaching Hospital Trust (LTHT) and to provide a discussion paper which will go to Executive Board.

ACTION: To take off-line what information is required to provide assurance to the NEDs regarding the perceived opportunity referenced in the Benchmarking paper – **RH/OW/GB/AB/KA**

ACTION: To produce a paper for discussion at Executive Board regarding how we address on-going CIP requirements – **GB**

The Committee **NOTED** the contents of the report.

154/20 TREASURY MANAGEMENT

The Deputy Director of Finance provided the Committee with an update on treasury management in 2020/21. Reference was made to the treasury management implications of COVID and in-year changes to the financial regime.

It was noted that here have been significant changes to the Trust's cash position in 2020/21 brought about by the financial arrangements supporting COVID coupled with changes to the debt regime. The Trust's business continuity plans through this period of escalation have prioritised treasury management in support of payroll and invoice payments. Even with the considerably healthier cash position, the focus on tightly managing cash and debt management will be retained.

The Committee **NOTED** the contents of the report and that the various initiatives around debt collection will continue to be enforced.

155/20 INTEGRATED PERFORMANCE REVIEW – OCTOBER 2020

The Chief Operating Officer highlighted the following core points from the IPR:-

- Complaints – deteriorating picture from last month, this continues to be reviewed and will be managed through the Quality Committee.
- Emergency Care Standards (ECS) – there have been a significant number of 12-hour trolley breaches both in October and November. Whilst this was a conscious decision to keep patients safe between the Executives directly involved from a clinical and operational perspective, it was felt that robust documentation was not in place. Retrospective QIAs will be carried out to ensure the decision is recorded correctly. There is now a zero tolerance in place and there has not been a 12-hour trolley wait in a week. In addition, the escalation process is also being reviewed.
- ECS 4-hour Performance – HRI is not in a good position which is part of discussions with the teams. The segregation of ED due to COVID is not helping the situation but this is not the only reason.
- Cancer – remains a positive position, however there are some concerns as demand remains higher than at Wave 1, capacity has been reduced and we are tracking patients. There is also a potential impact on our position as the national contract with the Independent Sector has been given notice and will finish on the

24 December 2020 when we will be on a new framework. Weekly conversations are taking place with the Independent Sector to look at options and this has also been raised with the ICS.

- Within the last month changes have been made with same-day emergency care. Medicine have moved to a new facility co-located with frailty and the facility for Surgery has been expanded. This will hopefully provide a benefit around flow moving into Qtr. 4
- Diagnostics 6 week – position improving at around 10% per month
- Mortality – potential concerns regarding our death rate in comparison to other organisations
- Backlog – we have 1500 patients with over 52 week waits - modelling to understand this position is taking place. A presentation to understand the backlog against planned care will be presented at the next meeting.

The Chief Executive took the opportunity to give an overview of the work which is being undertaken to explore our rate of death seen during COVID in comparison with Bradford Teaching Hospital (BTH). It was acknowledged that within our geographical footprint we have an older population, whereas BTH have a younger population but they have a greater ethnicity share. In addition, BTH have used different oxygen techniques than the rest of West Yorkshire which could have led to different outcomes, and all this will be explored.

The Assistant Director of Performance added the following highlights:-

- The overall performance for October was 70%
- Narratives have now started to be included within the IPR around the key indicators
- Long-term sickness appears to be a 'hot-spot'

The Chief Executive asked if there was anything required from this Committee which would be helpful to the Operations Team. The Chief Operating Officer responded by stating that in terms of the Patient Backlog, health inequalities should be reviewed and that wider conversation around reprioritisation would be useful. In addition, in terms of the work around Emergency Care an independent internal review would be valuable. The Chair was happy to assist in both the areas called out.

ACTION: To provide a presentation regarding Patient Backlog for the next meeting – **HB/PK, 11/1/21**

The Committee **NOTED** the contents of the October IPR.

GOVERNANCE

156/20 BOARD ASSURANCE FRAMEWORK (BAF)

The Company Secretary asked the Committee to note that both the Finance and Performance related risks have been presented for review. The Deputy Director of Finance reported that the Finance risks have been updated within the pack, however, at the next review certain values will be removed as these go out of date almost immediately.

The Target Scores were discussed, and it was suggested and agreed that BAF Risks 18.19 and 14.19 should be aligned as a target score of 12 for consistency purposes.

The Chair raised his concern with regard to the wording on the BAF risk 07.19, The Company Secretary agreed to refine the wording.

The Chair also queried Risk 05.20 which relates to services unable to maintain current levels due to COVID. It was felt that Finance & Performance Committee was not the primary Committee and asked if this risk was also being discussed at Workforce Committee and Quality Committee. The Company Secretary explained that this was the first Committee at which this risk could be discussed as most of the assurances were about performance. It was agreed that this would be discussed outside off-line.

ACTION: To review and align if feasible BAF Risks 18.19 and 14.19 to a Target Score of 12 – **GB/KA/AMcC**

ACTION: To refine the wording on the BAF Risk 07.19 in relation to Use of Resources – **AMcC/GB**

ACTION: To have a separate debate with regard to Risk 05.20 to agree the appropriate 'owner' Committee – **RH/AMcC/PL/HB**

157/20 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes or summaries thereof were received by the Committee:

- Draft Minutes from the Capital Planning Group held 17 November 2020
- C&GH A&E Delivery Board held 10 November 2020
- THIS Executive Board held 25 November 2020

It was noted that whilst summaries are being received, the Committee should also receive the actual Minutes either approved or in draft format, this will be followed up.

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

158/20 WORK PLAN 2020/21

The Work Plan was discussed with the following points highlighted:

- It was agreed that the THIS Commercial Strategy will be deferred a further month now to be reviewed at the meeting to be held **1 February 2021**

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

159/20 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board: -

- Phase 3 Staffing Review – paper to be finalised
- Stroke deep-dive actions - timelines to be received by mid-December.
- Month 7 reporting – a favourable variance due to staffing costs and we are fairly comfortable with the financial forecast at this point in time.
- Benchmarking Review – largely in line with our thinking in terms of opportunities but we need to develop the mechanisms for on-going CIP development and monitoring.

- IPR – overall performance was 70%, however, the following issues were highlighted:
    - Emergency Care
    - 12 Hour Trolley waits
    - Complaints
    - Cancer performance positive overall with one or two concerns
    - Mortality peer-review on-going in relation to recent COVID deaths
    - Review of the patient backlog to be discussed at the next meeting in January '21
    - Sickness absence at 10.5%. Long-term sickness a cause for concern

160/20 REVIEW OF MEETING

There were no points to note.

161/20 ANY OTHER BUSINESS

- Month 7, 2020/21 Financial Position – The Director of Finance referenced the late paper which highlighted the ICS position. It was noted that based at Month 7 the Acute providers are generally underspent and the CCGs are broadly in line with their plans.

- The Chief Executive asked the Committee to acknowledge the efforts and to note our thanks to Helen Barker and her colleagues for their determination in the face of the current circumstances. The Chair also extended the Committee's thanks to the entire workforce for their on-going work in caring for our patients.

DATE AND TIME OF NEXT MEETING:
Monday 11 January 2021, 11am – 1pm, via Microsoft Teams

ORGAN DONATION ENGAGEMENT GROUP MEETING
WEDNESDAY 13 JANUARY, 2021
VIA TEAMS

MINUTES

Present: Philip Lewer (Chair)
Paul Knight, Clinical Lead, Organ Donation
Jayne Greenhalgh, Specialist Nurse, Organ Donation
Caroline Winkley, Sister, ICU
Belinda Whiteley, Sister, Theatres
Malcolm Rogers, Donor Family Representative
Karen Piotr, Ambassador
Gary Boothby, Director of Finance
Huw Masson, A&E Consultant
Sarah Whittingham, Nursing Line Manager, Organ Donation
Kim Maloney, ODP, CHFT
Jenny Taylor, Finance
Annette Bell, Governor
Caroline Wright, Communications Team
Rebecca Johnstone, Admin Team Leader, Operating Services and Critical Care

Apologies: None

Minutes of the Last Meeting

The minutes of the last meeting were agreed as a true record.

Donation Activity

Jayne reported that we have had no missed referrals. Since April, 2020 we have had:
11 consented donors
10 proceeding donors (one did not die in timescales)
From the 10 proceeding, 5 were DBD (donor after brain death), 5 were DCD (donor after circulatory death)
24 organs plus tissues were retrieved from these 10 donors

For the first six months of the year CHFT had the highest number of donations in the region.

Jayne reported that the six month report was published recently and we came out really well, including 100% SNOD presence. We had a couple of missed chances of neurological death testing, but there were reasons why we could not test. Jayne thanked everyone involved for such an amazing performance when we are all working so hard in difficult times.

Missed Opportunities and Action Taken

No missed opportunities.

Legislation Change

Jayne reported that the law changed last year. From a unit perspective this should not make any difference at all to the approach to families and referrals.

Donor Recognition Funding and Finance

Jenny reported that we still have £14,000 available. Please let her know if you know of anything that has been spent. Please give any ideas to Jenny about how to spend the funds. Paul stated that, as an Organ Donation Committee, we have a responsibility to spend the funds wisely and we need plans for the funds. Malcolm pointed out we have the Transplant Games in Leeds on 5 – 8 August this year and the organisers have asked whether Organ Donation Committees could make a contribution towards the running costs. This would give us an opportunity to support them and spend the money wisely. There will be SNOD presence there for questions and answers. Sarah will find out how much they are looking at us contributing and let us know. Paul agreed this is a very worthy cause and the rest of the group had no concerns about using some of the funds for this purpose.

Promotional Activity/Organ Donation Week

Caroline Wright reported that the Piece Hall in Halifax lit up in pink for Organ Donation and are always great supporters of Organ Donation Week.

Jovial Man – Comms secured front page of the Yorkshire Post coverage for presentation of Jovial Man. We need to remember to invite the family up for the day when we can.

Paul stated that the Comms Team is brilliant and does a great job for the Organ Donation Group. However, the group is not just about clinical staff and we need a group of engaged people to do other things. Paul wondered whether anyone would want to take a more active interest in supporting promotion. Karen reported that she is still giving talks virtually and this is working really well. Karen is happy to be involved with CHFT. Paul said we need a co-ordinator to engage with our local population, though very few schools have wanted to engage with us and we have not had any requests. Caroline Wright will look into speaking with local authority communications teams to see whether they would like information in schools. Karen and Gary will meet outside this meeting to see what they can do. Malcolm suggested that when the next ambassador recruitment takes place (possibly next year), we can maybe find some local people to engage, which will take some stress off the medical staff.

Operational Matters Escalated from Clinical Areas: ED, ICU, Theatres

Huw reported that the ED has no issues. Everyone seems to know about organ donation and are getting on with it. Jayne reported that our new link nurse in ED, Philip Arrowsmith, is keen to take things forward and if Huw needs anything, Philip is taking the lead in ED. Kim reported that no-one has mentioned any particular concerns. Jayne will ask Philip for a photograph of himself and send it to Caroline for Comms.

Feedback to Trust Board

Philip reported that, as Chair, he reports directly to Board and his report from this meeting is recorded in the Board minutes.

Policies and Guidelines

Paul said he hopes to get some guidance into ICU after Covid. Philip offered him support with this.

Review of Governance Structure/ Terms of Reference

Nothing discussed.

YODELS

Jayne reported that YODELS courses are not taking place at the moment. She will report back at our next meeting. There are posters all over the hospitals regarding general education. Other than that, any training is currently ad hoc.

Yorkshire Organ Donation Committee – Role as Chair

Malcolm reported that he has become Chair of the Yorkshire Organ Donation Committee. He described his role as:

1. To try and improve information and ideas across each Trust. There are currently no formal networks between Trusts, but Malcolm hopes to help facilitate the sharing of best practice across committees. He suggested arranging a regional meeting of Trust Chairs.
2. Malcolm has concerns regarding communication flows. This year he hopes to address family consent work, a TV campaign with a BAME family (maybe running a campaign with Gogglebox) to improve communication between the central and Trust areas.

Malcolm reported that he has seen this committee change massively in the last couple of years with more engagement from other members. He said it has been lovely working with us all and thanked us for all our hard work. Malcolm hopes to keep in touch and Paul thanked him for his work with the group.

Any Other Business

Paul thanked everyone for a productive and useful meeting. He will chase up theatre and ICU about what they are going to do with their organ donation funding. Hopefully we will be able to give a good donation to the Transplant Games.

Date and Time of Next Meeting

Wednesday 7 July, 202 at 10.30 am – via Teams.

2. INFORMATION TO RECEIVE

a. Council of Governors Calendar 2021 and meeting dates

b. Updated Register of Council of Governors

2020-21 MEETING SCHEDULE FOR GOVERNORS

Calderdale and Huddersfield NHS Foundation Trust

Meeting Type	Date	Time	Venue
Annual General Meeting Attend: All	Wednesday 7 October 2020	5.00 – 6.30 pm	Via Microsoft Teams
Council of Governors Meeting Attend: All	Thursday 22 October 2020	2:00 – 3:15 pm (Private) 3:30 – 5:30 pm (Public)	Via Microsoft Teams
Medical Divisional Reference Group Meeting Attend: John Gledhill - Alison Schofield - Linzi Smith – Stephen Baines	~~Wednesday 4 November 2020~~ **Cancelled**	1.30 – 3.00 pm	Via Microsoft Teams
FSS Divisional Reference Group Meeting Attend: Peter Bamber - Annette Bell - Lynn Moore - Sally Robertshaw - Veronica Woollin	~~Monday 9 November 2020~~ **Cancelled**	11.00 am – 12.30 pm	Via Microsoft Teams
Community Divisional Reference Group Meeting Attend: Stephen Baines - Annette Bell - Lynn Moore - Sheila Taylor - Chris Owen	~~Monday 9 November 2020~~ **Cancelled**	1.30 – 3.00 pm	Via Microsoft Teams
Surgery Divisional Reference Group Meeting Attend: Jude Goddard - Rosie Hoggart - Christine Mills - John Richardson - Chris Owen	~~Tuesday 10 November 2020~~ **Cancelled**	1.30 – 3.00 pm	Via Microsoft Teams
Estates & Facilities Services Group Meeting Attend: Alison Schofield - Annette Bell - John Gledhill - John Richardson - Sheila Taylor	~~Thursday 12 November 2020~~ **Cancelled**	1.30 – 3.00 pm	Via Microsoft Teams
Joint Board of Directors / Council of Governors Workshop Attend: All	Friday 20 November 2020	1:00 – 4:00 pm	Via Microsoft Teams
Governors / Non-Executive Directors Informal Workshop Attend: All	Tuesday 15 December 2020	12:30 – 4:30 pm	Via Microsoft Teams

2020-21 MEETING SCHEDULE FOR GOVERNORS

Calderdale and Huddersfield NHS Foundation Trust

2021	Date	Time	Venue
Council of Governors Meeting Attend: **All**	Thursday 28 January 2021	2:00 – 3:15 pm (Private) 3:30 – 5:30 pm (Public)	Via Microsoft Teams
Estates & Facilities Services Group Meeting Attend: Alison Schofield - Annette Bell - John Gledhill - John Richardson - Sheila Taylor	~~Friday 5 February 2021~~ **Cancelled**	1.30 pm – 3.00 pm	Via Microsoft Teams
Surgery Divisional Reference Group Meeting Attend: Jude Goddard - Rosie Hoggart - Christine Mills - John Richardson - Chris Owen	~~Monday 8 February 2021~~ **Cancelled**	1.30 pm – 3.00 pm	Via Microsoft Teams
Community Divisional Reference Group Meeting Attend: Stephen Baines - Annette Bell - Lynn Moore - Sheila Taylor - Chris Owen	~~Tuesday 9 February 2021~~ **Cancelled**	1.30 pm – 3.00 pm	Via Microsoft Teams
Governors / Non-Executive Directors Informal Workshop Attend: **All**	Thursday 11 February 2021	3:00 – 5:00 pm	Via Microsoft Teams
Medical Divisional Reference Group Meeting Attend: John Gledhill - Alison Schofield - Linzi Smith – Stephen Baines	~~Monday 22 February 2021~~ **Cancelled**	10.30 am – 12 noon	Via Microsoft Teams
FSS Divisional Reference Group Meeting Attend: Peter Bamber - Annette Bell - Lynn Moore - Sally Robertshaw - Veronica Woollin	~~Thursday 25 February 2021~~ **Cancelled**	2.00 pm – 3.30 pm	Via Microsoft Teams
Council of Governors Meeting Attend: **All**	Thursday 22 April 2021	2:00 – 3:15 pm (Private) 3:30 – 5:30 pm (Public)	Via Microsoft Teams
Joint Board of Directors / Council of Governors Workshop Attend: **All**	Tuesday 11 May 2021	1:00 – 4:00 pm	Via Microsoft Teams

2020-21 MEETING SCHEDULE FOR GOVERNORS

Calderdale and Huddersfield NHS Foundation Trust

Estates & Facilities Services Group Meeting Attend: Alison Schofield - Annette Bell - John Gledhill - John Richardson - Sheila Taylor	Thursday 3 June 2021	10.30 am – 12 noon	Via Microsoft Teams
Medical Divisional Reference Group Meeting Attend: John Gledhill - Alison Schofield - Linzi Smith – Stephen Baines	Monday 7 June 2021	1.30 pm – 3.00 pm	Via Microsoft Teams
FSS Divisional Reference Group Meeting Attend: Peter Bamber - Annette Bell - Lynn Moore - Sally Robertshaw - Veronica Woollin	Wednesday 9 June 2021	10.30 am – 12 noon	Via Microsoft Teams
Community Divisional Reference Group Meeting Attend: Stephen Baines - Annette Bell - Lynn Moore - Sheila Taylor - Chris Owen	Monday 14 June 2021	10.30 am – 12 noon	Via Microsoft Teams
Surgery Divisional Reference Group Meeting Attend: Jude Goddard - Rosie Hoggart - Christine Mills - John Richardson - Chris Owen	Monday 14 June 2021	1.30 pm – 3.00 pm	Via Microsoft Teams
Council of Governors Meeting Attend: **All**	Thursday 15 July 2021	2:00 – 3:15 pm (Private) 3:30 – 5:30 pm (Public)	Via Microsoft Teams
Governors / Non-Executive Directors Informal Workshop Attend: **All**	Thursday 16 September 2021	3:00 – 5:00 pm	Via Microsoft Teams
Council of Governors Meeting Attend: **All**	Thursday 21 October 2021	2:00 – 3:15 pm (Private) 3:30 – 5:30 pm (Public)	Via Microsoft Teams
Surgery Divisional Reference Group Meeting Attend: Jude Goddard - Rosie Hoggart - Christine Mills - John Richardson - Chris Owen	Monday 1 November 2021	10.30 am – 12.00 pm	Via Microsoft Teams
Joint Board of Directors / Council of Governors Workshop Attend: **All**	Friday 19 November 2021	1.00-.00pm	Via Microsoft Teams
Medical Divisional Reference Group Meeting Attend: John Gledhill - Alison Schofield - Linzi Smith – Stephen Baines	Monday 1 November 2021	1.30 pm – 3.00 pm	Via Microsoft Teams

2020-21 MEETING SCHEDULE FOR GOVERNORS

Calderdale and Huddersfield NHS Foundation Trust

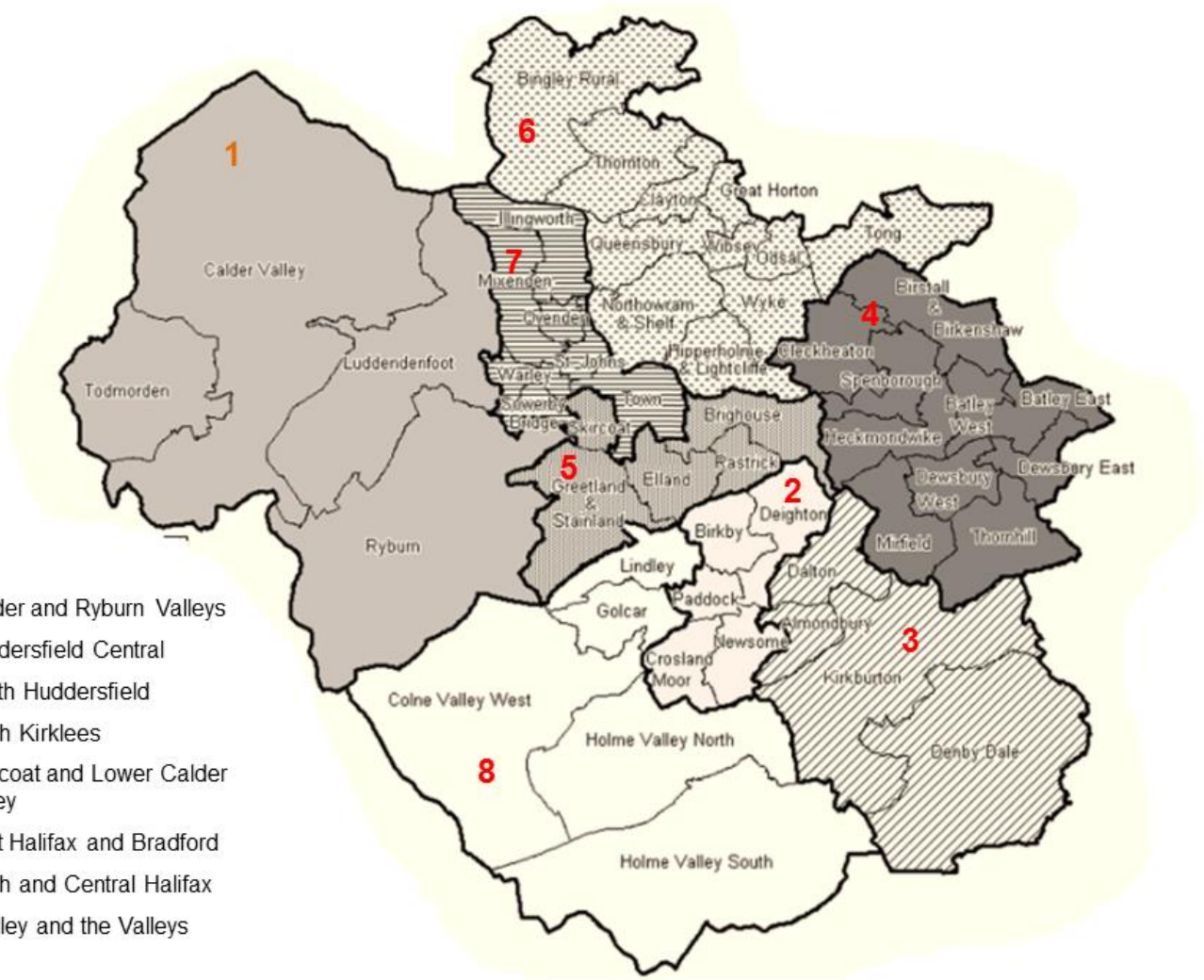
Community Divisional Reference Group Meeting Attend: Stephen Baines - Annette Bell - Lynn Moore - Sheila Taylor - Chris Owen	Tuesday 2 November 2021	10.30 am – 12 noon	Via Microsoft Teams
Estates & Facilities Services Group Meeting Attend: Alison Schofield - Annette Bell - John Gledhill - John Richardson - Sheila Taylor	Wednesday 3 November 2021	1.30 pm – 3.00 pm	Via Microsoft Teams
FSS Divisional Reference Group Meeting Attend: Peter Bamber - Annette Bell - Lynn Moore - Sally Robertshaw - Veronica Woollin	Thursday 4 November 2021	10.30 am – 12 noon	Via Microsoft Teams
Governors / Non-Executive Directors Informal Workshop Attend: **All**	Tuesday 14 December 2021 - 12.30pm	12.30pm-4.30pm	Via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

COUNCIL OF GOVERNORS REGISTER
AS AT 1 JANUARY 2021

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
PUBLIC – ELECTED				
1 – Calder and Ryburn Valleys	Jude Goddard	19.7.18	3 years	2021
1 – Calder and Ryburn Valleys	**VACANT SEAT**			
2 – Huddersfield Central	Sheila Taylor	19.7.18	3 years	2021
2 – Huddersfield Central	Christine Mills	19.7.18	3 years	2021
3 – South Kirklees	Chris Owen	17.7.19	3 years	2022
3 – South Kirklees	John Richardson	15.9.17 Extended 1 year	3 years 1 year	2020 2021
4 – North Kirklees (Cons. 4 from 15.11.17)	Veronica Woollin	15.9.16 17.7.19	3 years 3 years	2019 2022
4 – North Kirklees (Reserve Register from 17.7.19)	**VACANT SEAT**			
5 – Skircoat and Lower Calder Valley	Stephen Baines	15.9.16 17.7.19	3 years 3 years	2019 2022
5 – Skircoat and Lower Calder Valley	Brian Richardson	18.9.14 15.9.17 Extended 1 year	3 years 3 years 1 year	2017 2020 2021
6 – East Halifax and Bradford	Annette Bell	19.7.18	3 years 3 years	2018 2021
6 – East Halifax and Bradford	**VACANT SEAT**			
7 – North and Central Halifax	Lynn Moore	18.9.14 Extended 1 year	3 years 3 years 1 year	2017 2020 2021
7 – North and Central Halifax	Alison Schofield	15.9.17 Extended 1 year	3 years 1 year	2020 2021
8 – Lindley and the Valleys	**VACANT SEAT**			
8 - Lindley and the Valleys	John Gledhill	17.7.19	3 years	2022

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
STAFF – ELECTED				
9 - Drs/Dentists	Dr Peter Bamber	15.9.17 Extended 1 year	3 years 1 year	2020 2021
10 - AHPs/HCS/ Pharmacists	Sally Robertshaw	17.7.19	3 years	2022
11 - Mgmt/Admin/ Clerical	Linzi Jane Smith	15.9.17 Extended 1 year	3 years 1 year	2020 2021
13 – Nurses/Midwives	**VACANT SEAT**			
13 – Nurses/Midwives	Rosemary Hoggart	17.7.19	3 years	2022
NOMINATED STAKEHOLDER				
University of Huddersfield	Dr Joanne Garside	01.01.21	3 years	2024
Calderdale Metropolitan Council	Cllr Megan Swift	3.10.17	3 years	2020
Calderdale Huddersfield Solutions Ltd (CHS)	Jayne Taylor	17.7.19	3 years	2022
Kirklees Metropolitan Council	Cllr Lesley Warner	14.6.19	3 years	2022
Healthwatch Kirklees	Helen Hunter	2.10.17	3 years	2020
Locala	Chris Reeve	21.11.17 21.11.20	3 years 3 years	2020 2023
South West Yorkshire Partnership NHS FT	Salma Yasmeen	18.10.17 18.10.20	3 years 3 years	2020 2023



1 Calder and Ryburn Valleys
2 Huddersfield Central
3 South Huddersfield
4 North Kirklees
5 Skircoat and Lower Calder Valley
6 East Halifax and Bradford
7 North and Central Halifax
8 Lindley and the Valleys