Public Board of Directors

3 September 2020

The following items are for Board Assurance

1. Nursing and Midwifery Safer Staffing

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	3 September 2020
Meeting:	Board of Directors
Title:	Nursing and Midwifery Safer Staffing Update Report
Author:	Lindsay Rudge, Deputy Director of Nursing Michelle Bamforth, Head Nurse for Workforce and Professional Development
Sponsoring Director:	Ellen Armistead, Executive Director of Nursing / Deputy Chief Executive
Previous Forums:	None

Actions Requested:
To note.

Purpose of the Report

The purpose of this report is to provide assurance to the Board of Directors that the nursing and midwifery workforce has been reviewed in line with national guidance. The report provides details on the Nursing and Midwifery workforce at Calderdale and Huddersfield NHS Foundation Trust (CHFT) as it responds to the Covid -19 pandemic and will evaluate if the current establishment provides the right number of staff, with the right skills in the right place at the right time.

Key Points to Note

- A 6 monthly review has been completed in line with guidance.
- Registered Nurse vacancy position continues to be a risk within the workforce and remains on the risk register Risk 3645.
- The Trust has increased the number of training placements at CHFT.
- The Nursing Associate training programme continues to develop in line with the national plan.
- CHFT continue to utilise digital technology to support analysis of patient's dependency and acuity aligned to the workforce.
- CHFT in response to the COVID Pandemic followed guidance and put in place staffing plans to support the incident response.
- The Trust has established new work force models to support current capacity and demand which places an increased requirement for the registered and unregistered workforce across the trust in supporting enhanced models across in patient and community services, social distancing, virtual visiting, the relatives' telephone line and end of life care.

Calderdale and Huddersfield NHS Foundation Trust

- As the Trust resets services this will increase risk to the current workforce gaps which will need to be assessed across the totality of the workforce including the substantive and flexible workforce/agency capacity.

EQIA – Equality Impact Assessment

Ethnicity, age, disability, sexuality, socio-economic status, religious beliefs, non-English speakers and being a member of a social minority (e.g. migrants, asylum seekers, and travellers) may all influence rates of access to CHFT patient services. These factors may also influence the level of nursing staff required to provide safe care.

Consideration of the impact of equality issues on the provision of safe care to all patients is an integral part of standard nursing practice. As such, considering equality issues that may influence the provision of safe staffing forms an integral part of the scoping document.

Recommendation

The Board is asked to note the assurance of ongoing monitoring of nurse and midwifery staffing levels across in-patient areas in line with national requirements and that the recommendations in the report are being taken forward and will be monitored via the appropriate Committees

Calderdale and Huddersfield NHS Foundation Trust

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Calderdale and Huddersfield NHS Foundation Trust

1.0 INTRODUCTION

The purpose of this report is to provide an update and assurance to the Board of Directors that the nursing and midwifery workforce has been reviewed in line with national guidance. The report provides details on the nursing and midwifery workforce numbers and skill mix at Calderdale and Huddersfield NHS Foundation Trust (CHFT) over the last six months and describes how it has responded to the Covid-19 pandemic. It provides an evaluation if the current workforce establishment provides the right number of staff, with the right skills in the right place at the right time.

The Nursing and Midwifery workforce has made a substantial contribution during the Covid -19 pandemic. The national “surge” in Critical Care, ED and Respiratory Care provision required the nursing workforce to mobilise at pace to increase capacity in these specialities and perform an urgent and rapid learning needs analysis to facilitate effective deployment across the workforce.

As the Trust works through its reset and stabilisation plans, the nursing workforce has developed sustainable, responsive workforce models to ensure we have the right nursing capacity and capability to deliver care across services. Where workforce models remain enhanced or reduced to support current and predicted demand there are colleagues deployed to or from services to support the nursing requirement in these services.

2.0 CURRENT POSITION/RESPONSE TO COVID-19

2.1 Deployment response

In order to meet the initial rapid and significant demand to staff segregated ED’s cross site, a respiratory isolation ward and enhanced critical care capacity the nursing workforce completed a Trust wide skill’s set mapping programme of the nursing and midwifery workforce to specifically identify colleagues with skills to work in and support the following areas:

- ED
- Critical care
- Respiratory
- Education and training

The data sets were added to a central database to allow the senior nursing team to align nursing skill and competency with the required demand, staff identified were mobilised to key areas incrementally and aligned to the Trusts phased plan.

Staffing numbers were further enhanced by:

- Releasing colleagues from services running with reduced activity (OPD, operating theatres, endoscopy and non-ward based/specialist nurse)
- Deploying nursing colleagues from the local independent sector hospitals
- Nursing colleagues from community partners from LOCALA supported paediatrics services and community services
- Elective surgical specialities CRH Ward 8b and HRI Wards 3, 10, 11 and 22 retracted and merged releasing nursing capacity across the hospital sites.
- CRH Ambulatory unit merged with HRI Ambulatory unit and staff were deployed into HRI Ward 10 and CRH AF Wards
- Movement of non-ward based and specialist nurses into front line service delivery.
- Endoscopy relocated to single site model
- DPU and DSU retracted and activity achieved through Main Theatres
- Revised theatre workforce model implemented
- Deployment of undergraduate nurses, midwifes and AHP's to strengthen the workforce and increase capacity care during the planned surge in activity

Table 1 shows the volumes of staff who were deployed to critical areas

Table 1

	Trust Registered staff deployed into area	BMI Staff Deployed into Area	Unregistered staff deployed into area
ICU Escalation Phases	184	4	100
A&E	33		28
CRH Ward 5c	39		17
CRH 2a o2 Ward	17		14
HRI Ward 10 O2 Ward	21		8

2.2 Training response

To support those staff returning from academia, retirement and colleagues deployed across areas, the education team developed a robust and responsive training offer. These training packages were delivered to innovative use of roles enabling the upskilling of existing staff, applying skills to new settings, and increasing multidisciplinary team working.

The training packages developed aligned to national guidance and delivered in the following key areas:

- ED
- End of Life care
- Respiratory care
- Critical Care

A particular focus was given to supporting and developing non-critical care staff to work on ICU and respiratory care areas where advanced respiratory support was being delivered during the pandemic. A condensed critical care and respiratory package was delivered sequentially and was mapped to the critical care emergency induction framework. The Trust followed national guidance around staffing ratios within critical care facilities and developed a “category of nursing chart” to enable efficient and safe rostering.

3.0 RETRACTION PLANS

3.1 Reset and Stabilisation

As the Trust began to reset its operational plans, the nursing workforce responded by aligning its capacity to meet the ongoing demand. In the first instance this required careful and systematic retraction of deployed colleagues to substantive posts.

In patient staffing was re-set from 20 July 2020, back to a base position with the exception of the following areas due to enhanced models or retracted service provision.

- Emergency departments
- Critical Care,
- Respiratory services
- Outpatient Services
- Elective Orthopaedic
- Elective General Surgery (super green pathway)

The following table provides as overview of the gap against the planned models as of July 2020 and does not include in these assumptions the following

- Relatives Line
- Virtual Visiting Service
- Elective Orthopaedic ward

*This data is inclusive of in-patient ward/deps, DN services & OPD

Division	Pre Covid budgeted (WTE)	Pre Covid actual (WTE)	Gap (WTE)	Post Covid budgeted (WTE)	Post Covid actual (WTE)	Gap (WTE)
Medicine						
RN	476.77	415.84	**-57.2**	515.71	427.38	**-88.33**
HCA	297.7	301.61	**+3.96**	356.73	322.94	**-33.79**
Surgery						
RN	**450.78**	**387.95**	**-62.84**	**409.9**	**383.47**	**-26.43**
HCA	**208.48**	**206.5**	**-1.98**	**208.55**	**191.17**	**-17.35**
FSS						
RN/RM	**301.43**	**281.51**	**-19.49**	**294.13**	**266.24**	**-27.89**
HCA	**100.1**	**97.56**	**-2.54**	**101.31**	**63.08**	**-38.23**
Community						
RN	**143**	**137.3**	**-5.7**	**143**	**140.13**	**-2.87**
HCA	**23.29**	**25.68**	**+2.39**	**23.29**	**20.8**	**-2.49**
Total						

Medicine:

- *Vacancy gap increased due to enhanced models for both RN's and HCA's*

Surgery:

- *RN Vacancy gap reduced due to retraction of ward 3, 8b and ward 10 only operating at 10 beds*
- *HCA vacancy gap increased due to enhanced models in ICU, 22,*
- *8B staff deployed to Respiratory*

FSS:

- *Budget position changed due to reduced models on 4C and NICU*
- *OPD staff still deployed in med/surg*

***Staff on Virtual Visiting & Relatives Line not included in Divisional wte*

- Virtual Visiting staff in post = 4.63 wte (0.6RN and 4.03 HCA/A&C)
- Relatives Line staff in post = 14.48 wte RN

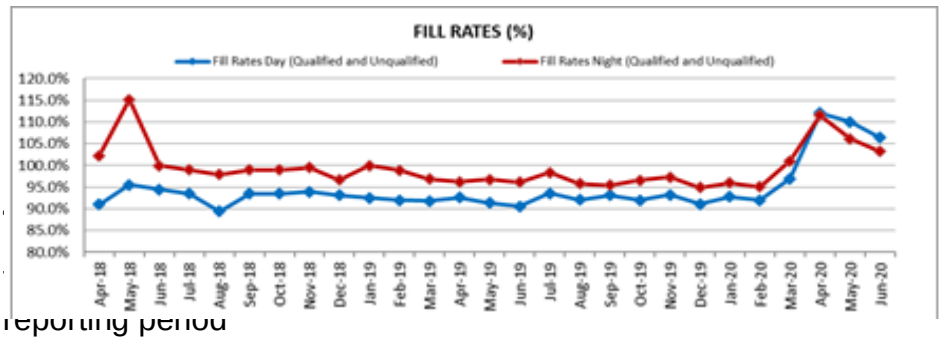
4.0: SAFE STAFFING - CARE HOURS PER PATIENT DAY (CHPPD) DATA DURING THE PANDEMIC

To ensure safe staffing was achieved during the reporting period and the peak of the pandemic, particular focus was given to the use of safe care live and the governance processes around the daily staffing meeting.
To provide assurance that the planned workforce was able to deal with capacity and demand the divisional teams continued to hold routine confirm and challenge meetings and populate the divisional dashboards to facilitate overview on staffing impact linked with sickness, shielding colleagues and staffing mobilisation.

4.1 Fill rates

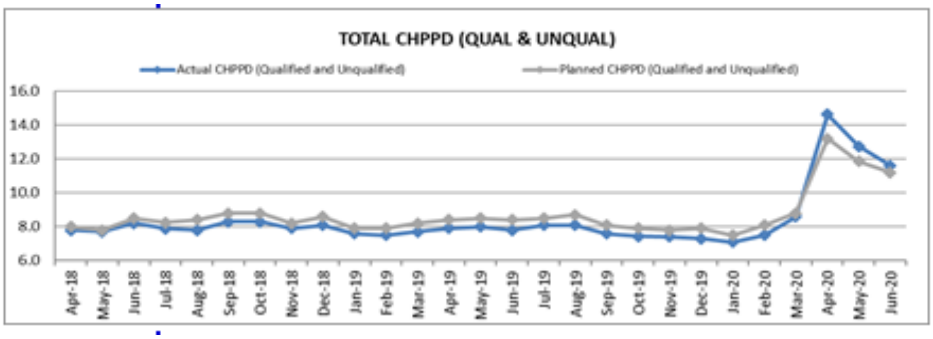
Table 1 indicates the achieved filled rates at CHFT during the reporting period

Table 1



CHFT during the

Table 2



Average fill rates and realised CHPPD have been maintained during the reporting period, giving assurance that nurse staffing levels have met patient demand needs.

5.0 QUALITY IMPACT ON NURSING AND MIDWIFERY STAFFING LEVELS

The nursing and midwifery clinical work stream is undertaking a detailed review of the quality impact across a range of nurse sensitive indicators and will report this to the Quality committee on completion.

6.0 WELLBEING AT WORK - SICKNESS AND ABSENCE RATES

The nursing workforce recognises the ongoing impact of the COVID-19 pandemic on NHS staff wellbeing. In response to this and building on the NHS People Plan intention to build a new offer for staff, the nursing workforce has given this element significant focus supported by colleagues from within workforce and organisational development departments (WOD). During the peak of the pandemic and as the Trust resets, the nursing workforce has:

- Offered daily coaching/debrief sessions for critical care staff
- Ensuring staff feel safe and protected
- Ensuring safe spaces for rest and recuperation
- Health and wellbeing conversations with managers, WOD colleagues and senior team
- Psychological support and treatment
- Appraisal of flexible working
- Close monitoring of shielding colleagues
- Encouraged compliance with the trusts Health and Wellbeing Risk Assessment

6.1 Sickness and absence levels.

Table 4 shows the sickness level at the Trust during the reporting period. Although the overall trend remains fairly consistent, spikes in certain divisions can be seen, this is possibly attributed to the large amount of staffing movement/deployment during this time and presents particular importance to the focus on wellbeing in the workplace.

Table 4:

Calderdale and Huddersfield NHS Foundation Trust

Qualified Nursing & Midwifery

	Total Absence %					
Division	2020/01	2020/02	2020/03	2020/04	2020/05	2020/06
372 Community L3	5.44%	4.70%	5.35%	5.93%	4.52%	2.78%
372 Corporate L3	5.91%	7.02%	6.72%	4.87%	4.48%	2.96%
372 Families & Specialist Services L3	4.46%	3.97%	4.87%	6.23%	4.82%	5.18%
372 Health Informatics L3						
372 Medical L3	4.83%	4.47%	5.54%	7.22%	6.36%	4.99%
372 Surgery & Anaesthetics L3	4.41%	4.10%	4.89%	6.48%	5.15%	3.84%
Grand Total	**4.75%**	**4.38%**	**5.24%**	**6.55%**	**5.38%**	**4.38%**

Unqualified Nursing

	Total Absence %					
Division	2020/01	2020/02	2020/03	2020/04	2020/05	2020/06
372 Community L3	7.99%	11.37%	14.25%	13.98%	7.84%	8.36%
372 Corporate L3	6.28%	6.74%	8.48%	13.73%	17.98%	7.17%
372 Families & Specialist Services L3	7.36%	4.70%	3.85%	6.66%	6.79%	3.98%
372 Medical L3	5.43%	5.39%	6.73%	7.40%	6.88%	5.90%
372 Surgery & Anaesthetics L3	7.29%	5.61%	6.38%	11.26%	9.29%	7.86%
Grand Total	**6.46%**	**5.65%**	**6.51%**	**8.91%**	**8.00%**	**6.27%**

7.0 ESTABLISHMENT REVIEWS / RESET MODELS

The purpose of the review is to inform the Trust Board of the latest position in relation to Nursing and Midwifery staffing in line with the expectations of NHS England (National Quality Board – NQB's ten expectations) and the Care Quality Commission. The review provides assurances that nursing staffing, capacity and capabilities are monitored, reviewed and established in line with national guidance.

7.1 Medical Division: Update since last review:

Divisional colleagues provided an update on the current workforce position within the division and confirmed that the only proposed changes to WFM were to support the enhanced models in critical areas as a result of Covid -19 which were approved through IMT. All other models remained as agreed and planned in the December 2019 staffing reviews. Further review is being undertaken of the Ambulatory and medical day case service at HRI.

7.2 Surgical Division

The surgical division is currently supporting an enhanced workforce model to support a super green pathway for elective surgical procedures

A further non recurrent funding requirement was identified based on revised workforce models for ICU, Ward 10 (10 bed and 20 bed models), Ward 11, Ward 8c and the

Discharge Lounge. This will be achieved from other areas where staffing requirements are currently below work force model.

7.3 Community Division

There are no proposed changes to the WFM/establishment levels within community nursing services at present whilst further work is undertaken across partnerships to describe the enhanced models across community services/ care providers.

7.4 Families and Specialist Services Division

The divisional team reported that there were no plans to change models within maternity at this time. The Trust has commissioned Birth rate plus work and is awaiting the recommendations from this analysis.
Birth rate plus provides:

- An understanding of the total midwifery time required to care for women based on a minimum standard of providing one-to-one midwifery care throughout established labour
- A classification for intrapartum care which uses clinical indicators to assess the level of need of both mother and baby
- Collecting real time data on the length of time a woman required care during labour and delivery and an addition of extra midwife time for those with a high level of need/ intervention or emergency

This will further inform the continuity of carer programme and be factored into the next annual workforce planning exercise.
Proposals were supported to realign the paediatric WFM to make a more sustainable model to address the seasonal fluctuation in demand. This model could be achieved within existing budget and was supported.

A reduction in establishment was proposed and agreed for NICU based on the assumption of reduced activity and the reduction in cots. This has been approved through divisional PRM's and regional networks.

- The new model will support working towards achieving above 70% QIS as per BAPM guidance
- Provisions have been left to ensure sustainability and development of nurses onto the appropriate training programmes to achieve QIS Qualifications.

8.0 CONCLUSION

Nursing and Midwifery establishments are set, monitored and financed at appropriate levels in the Trust. The Trust continues to respond to both the local and national challenges in relation to the recruitment and retention of the workforce. There are clear governance arrangements and oversight in place to ensure that safe and sustainable staffing levels are achieved to ensure high quality compassionate care across the trust.

In response to this report, during 2020/21 we will be focusing on collaboration with local Health Education Institutes (HEIs) and Health Education England (HEE) to stabilise the vacancy gaps, make evidence based predictions in relation to growth, reduce turnover (retaining skilled staff), improve supply (through undergraduate programmes, apprenticeships, return to practice initiates and overseas recruitment) and prepare for the NMC 'future nurse' standards and consider implementation of the Nursing Associate role. In addition, we will be continuing to work with NHSi on our nursing and midwifery retention programme, which focuses on preceptorship, retire and return, flexible working models and career development.

9.0 RECOMMENDATIONS

The following recommendations from this report are:

- To undertake review process across all inpatient areas and departments through 2020/21 and reported on in the annual staffing review.
- To review the enhanced models (ED, Respiratory floor, Critical Care, Super Green Ward) to ensure the workforce models and skill mix are correct in 3 months
- Review additional WFM as changes are made as services are reset
- Report on other initiatives supporting the nursing workforce through existing governance structure committees (Education Committee, Nursing and Midwifery Committee, Workforce Committee).

10.0 REFERENCES

Ball, J. Murrelle, T. Rafferty, A. Morrow, E and Griffiths, P (2012): Care left undone during nursing shifts: association with workload and perceived quality indicators. *BMJ Journal.* Vol 23: Issue 2

National Quality Board (2016), *safe, sustainable and productive staffing. An improvement recourse for adult inpatient wards in acute hospitals*

National Quality Board (2016), *Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time*

National Quality Board (2018), *Updated guidance for safe, sustainable staffing. An improvement resource for adult in patient wards in acute hospitals*

Safer Care Nursing Tool (2014), Shelford Group

NHS Improvement (2018), *Developing workforce safeguards. Supporting providers to deliver high quality care through safe and effective staffing.*

2. Director of Infection Prevention Control Annual report (DIPC)

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 3rd September 2020
Meeting:	Board of Directors
Title:	Annual Director of Infection Prevention and Control (DIPC) Report
Author:	Jean Robinson, Matron Lead IPC Lindsay Rudge, Deputy Chief Nurse Anu Rajgopal, Infection Control Doctor
Sponsoring Director:	David Birkenhead, Executive Medical Director
Previous Forums:	Infection Prevention and Control Performance Board 24 August 2020

Actions Requested:
To note.

Purpose of the Report

To provide the Board of Directors an annual report of the position of performance and of Healthcare Associated Infections (HCAIs) for 2019-20.

Key Points to Note

- There was 1 trust apportioned Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 31 trust apportioned *Clostridium difficile* toxin (CDI) positive cases this year against a ceiling target of 40. All were subject to a Root Cause Analyses (RCA) – 5 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
- A cluster of 5 *Serratia marcesens* colonisations was identified on NICU and managed as an outbreak.
- There were 20 CHFT-attributed Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia which is an increase from 16 in 2018/19.
- The trust reported 28 *Escherichia coli* bacteraemia which is a reduction of 56% on the previous year's performance.
- There were 8 wards affected (either closed or restricted) with viral gastroenteritis, resulting in a total of 89 bed days lost in comparison to 106 bed days lost during 2018/19.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of compliance with the Hand Hygiene Policy for the year was 89%.

- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust intranet and internet sites. Three policies have been approved at Executive Board during 2019/20.
- ANTT reset was initiated on the 1st September 2019 with a baseline of 44%, this increased significantly to 84.63% by the end of March 2020.
- October/November Flu vaccination campaign commenced with the target of 75% uptake achieved.
- National Listeria Outbreak.
- COVID-19 pandemic – containment phase leading to pandemic.
- Flu POCT - led improvement in turnaround times and early diagnosis, improved management.
- The IPC team has worked with PHE and partner organisations in supporting outbreaks outside of CHFT

EQIA – Equality Impact Assessment

This report relates performance information relating to Infection Prevention and Control. It is not expected that the performance metrics reported will be significantly affected by ethnicity, however disability may predispose individuals to certain infections. The impacts of COVID due to ethnicity, age has been reported separately.

Recommendation

The Board is asked to note the assurances in the 2019/20 annual Infection Prevention Control report that:

- there were effective systems in place for infection prevention control (IPC) during the year
- the performance against key IPC targets in 2019/20 and areas for improvement for 2020/21
- the IPC team response to the Covid-19 pandemic

compassionate care

Calderdale and Huddersfield
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2019-20

Executive Summary

The Trust has a statutory responsibly to be complaint with The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and associated guidance (updated 2015) and the Care Quality Commission (CQC) guidance. Compliance is demonstrated through a self-assessed Healthcare Associated Infection (HCAI) programme of work and audit for 2019/20 that includes the 10 criteria identified in the code.

Evolving clinical practice, expanding services, emerging infections, antimicrobial resistance and an increase in vulnerable populations present new challenges for which a constant review of policies and procedures is essential.

This year has been one of exceptional challenge related to Infection Prevention and Control. The trust responded to the national outbreak of Listeria monocytogenes that occurred in April 2019 across several hospitals in England, no patients were affected at CHFT. In quarter 4 the Trust responded to the COVID-19 pandemic. In both instances the Trust has demonstrated a timely and unified response to protect both patients and staff.

This report demonstrates the continued commitment of the Trust to IPC and details the activities of the Infection Prevention and Control Team (IPCT) during the period of April 2019 to March 2020. The Director of Infection Prevention and Control (DIPC) who is also the Executive Medical Director leads the IPCT and reports directly to the Chief Executive.

Key points:

- There was 1 trust apportioned Meticillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia reported against a ceiling target of zero.
- There were 31 trust apportioned *Clostridium difficile* toxin (CDI) positive cases this year against a ceiling target of 40. All were subject to a Root Cause Analyses (RCA) – 5 of these cases were identified as potentially avoidable. Learning from the RCAs is fed into a Trust-wide action plan and divisional actions plans, to minimise the risk of patients acquiring CDI.
- A cluster of 5 *Serratia marcesens* colonisations was identified on NICU and managed as an outbreak.
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- There were 8 wards affected (either closed or restricted) with viral gastroenteritis, resulting in a total of 89 bed days lost in comparison to 106 bed days lost during 2018/19.
- Hand hygiene and bare below elbow (BBE) compliance was audited monthly by infection control link practitioners. The overall percentage of compliance with the Hand Hygiene Policy for the year was 89%.
- The Trust participated in the mandatory orthopaedic surgical site infection surveillance (SSIS) programme.
- All core policies, as required by the Hygiene Code 2008 (DH 2010), have been reviewed and have been published on the Trust intranet and internet sites. Three policies have been approved at Executive Board during 2019/20.
- ANTT reset was initiated on the 1st September 2019 with a baseline of 44%, this increased significantly to 84.63% by the end of March 2020.
- October/November Flu vaccination campaign commenced with the target of 75% uptake achieved.
- National Listeria Outbreak.
- COVID-19 pandemic – containment phase leading to pandemic.
- Flu POCT-led improvement in turnaround times and early diagnosis, improved management.
- The IPC team has worked with PHE and partner organisations in supporting outbreaks outside of CHFT

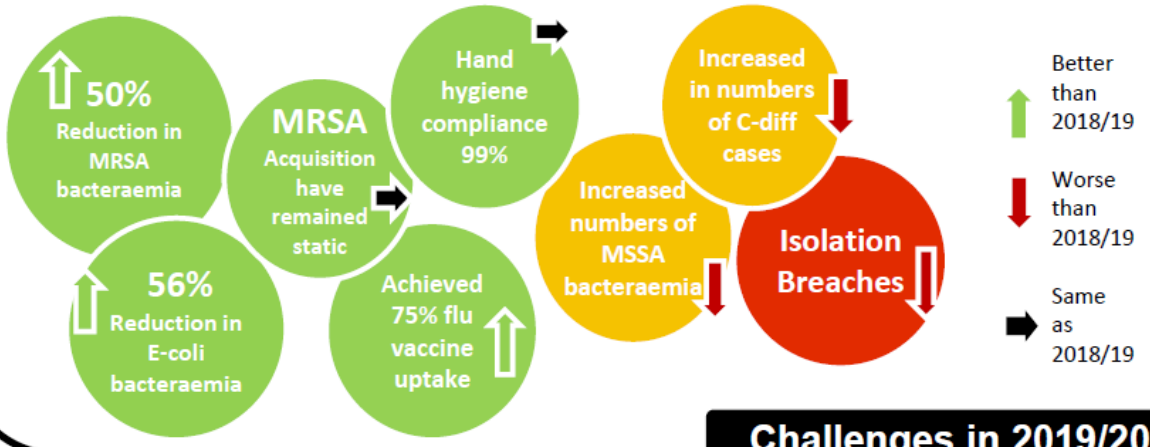
Calderdale and Huddersfield NHS Foundation Trust

Infection Prevention & Control 2019/20 highlight report

RESULT: safe, evidence based practice with reduction health associated infections.

REALITY 2019/20 with comparison to 2018/19

What we did well: What could be better: What needs significant improvement



Key achievements for 2019/20

- 56% reduction in E-coli bacteraemia
- 75% flu vaccine uptake
- Improved MRSA bacteraemia
- ANTT update 3 yearly from Sept – 84% compliance by the end of the year, up by 40%
- Point of care testing for influenza implemented
- PCR introduced for Norovirus testing
- Integrated working with divisions
- All Policies reviewed
- Audit programme completed

Challenges in 2019/20

Clostridium difficile reporting changed to both Hospital Onset healthcare Associated (HOHA) and Community Onset Healthcare Associated (COHA) – new systems introduced

Outbreak of Serratia in NICU

National Investigation of Listeria in Sandwiches

Initial response to the emergence of Covid-19

Data overview for 2019/20

MRSA (Bact): 1 Pending: 0	MRSA (HAI): 26	CDIFF: 26 COHA: 5 Prev: 7 Unprev: 24 Pending: 0	ECOLI: 28	MSSA: 20	KLEB: 11	PSEUDO: 10	Hand Hygiene: 99.3%	Isolation Breaches: 430

Contents

1. Infection Control Arrangements

The Director of Infection Prevention and Control (DIPC) leads the Infection Prevention and Control Team (IPCT), and is supported by the Matron Lead for IPC and the Infection Prevention and Control Doctor (IPCD).

Assurance pertaining to IPC is received and scrutinised by the Infection Control Committee, chaired by the IPCD, who then reports to the Quality Committee and to the DIPC directly. The Quality Committee and DIPC report to the Executive Board and the Board of Directors.

Full details of the Infection Control arrangements are available in the Trust Policy: Section A – Infection Prevention and Control Arrangements. Terms of Reference for the Infection Control Committee are available here:

See appendix 1, Calderdale and Huddersfield Foundation Trust: **Section A - Infection Prevention and Control Arrangements** *and appendix 2 Infection Control Committee (ICC) terms of reference.*

The Director of Infection Prevention and Control (DIPC) has presented the Trust Board with the following agenda items on IPC during 2019/20:

- The annual DIPC report 2018/19 – endorsed.
- Quarterly DIPC reports – endorsed.
- Quarterly Infection Control Committee minutes highlighting outbreaks and areas of concern and providing assurance around infection control practice across the organisation.
- Monthly Trust MRSA bacteraemia trajectory progress and areas of concern.
- Monthly Trust Clostridium *difficile* trajectory progress and areas of concern.
- Monthly Trust MSSA and E-coli bacteraemia figures.
- A narrative of any underperformance against target indicators is provided in the integrated board report, detailing actions being taken to mitigate risks and to support improvement to deliver against targets. .

The IPCT has a proactive approach with the emphasis on being visible, particularly on in-patient areas, so expert advice and support can be accessed**.**

The team also has a wider quality remit which includes attendance at corporate/divisional/partnership meetings, involvement in tender processes for services and procurement of equipment.

The IPCT was also involved in the review of various national guidelines including along with CHS colleagues the National Specifications for Cleanliness in the NHS.

Infection Control Budget 2019/20

The Infection Control Team has a budget of £550,464.00, of this £50,376.00 is for non-pay including licensing of ICNet surveillance IT system which during the reporting period has been upgraded phase, training expenses and other non-pay items. The Matron Lead is both the budget holder and budget manager. Excess costs associated with outbreaks are funded separately from within the Trust.

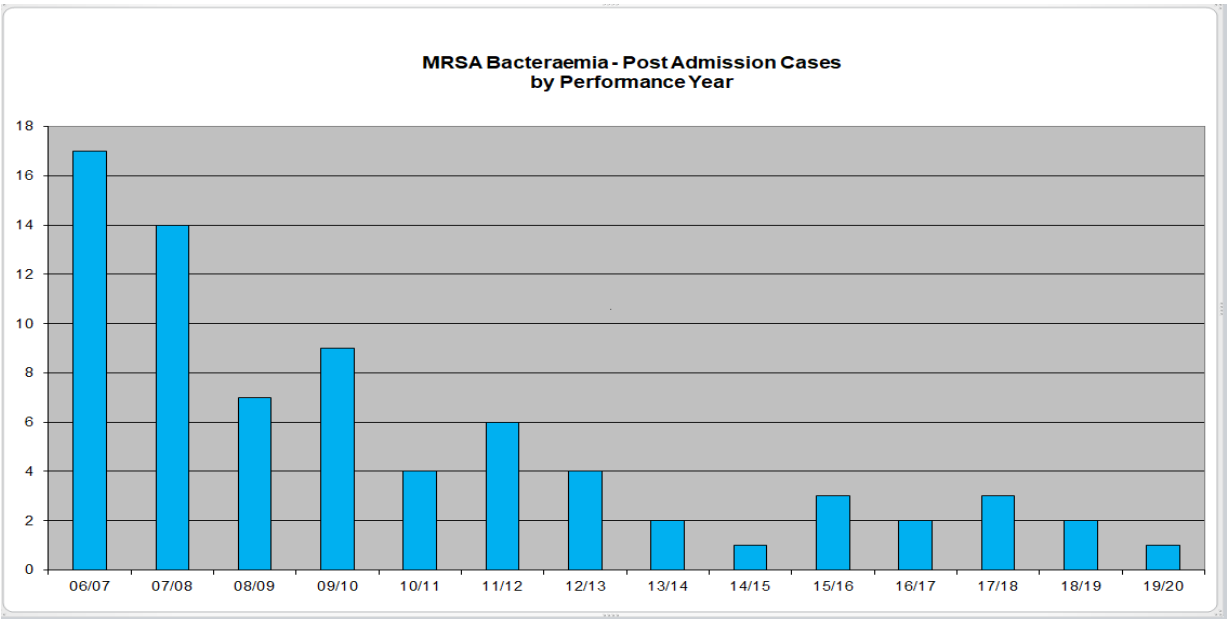
2. Mandatory reporting of Healthcare Associated Infections (HCAI)

Mandatory reports are made to Public Health England (PHE) of the following organisms causing the stated infection.

- *Staphylococcus aureus* bacteraemia (MRSA & MSSA)
- *Escherichia coli* bloodstream infections
- *Clostridium difficile* toxin positive infections diagnosed 48 hours after admission and COHAs.
- Orthopaedic Surgical Site Infection Surveillance (minimum 3 month period per annum)

Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia

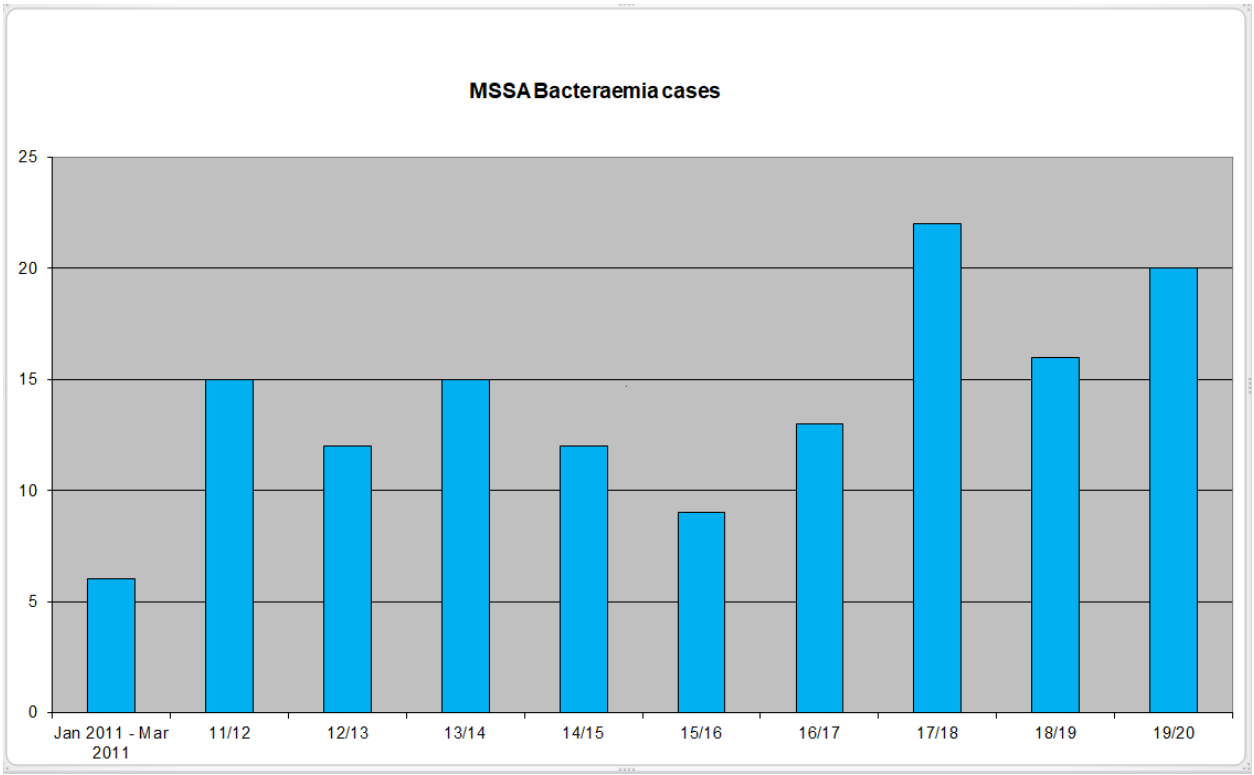
The total number of Trust-apportioned MRSA bacteraemia (blood stream infection) cases for the 2019/20 was 1 against a ceiling of zero, which is a reduction from 2 cases in 2018/19. The Trust ensures that these have a Post Infection Review (PIR) to identify if there were any lapses in care to aid prevention of further cases; this case was deemed as non-preventable.



Meticillin-sensitive Staphylococcus aureus

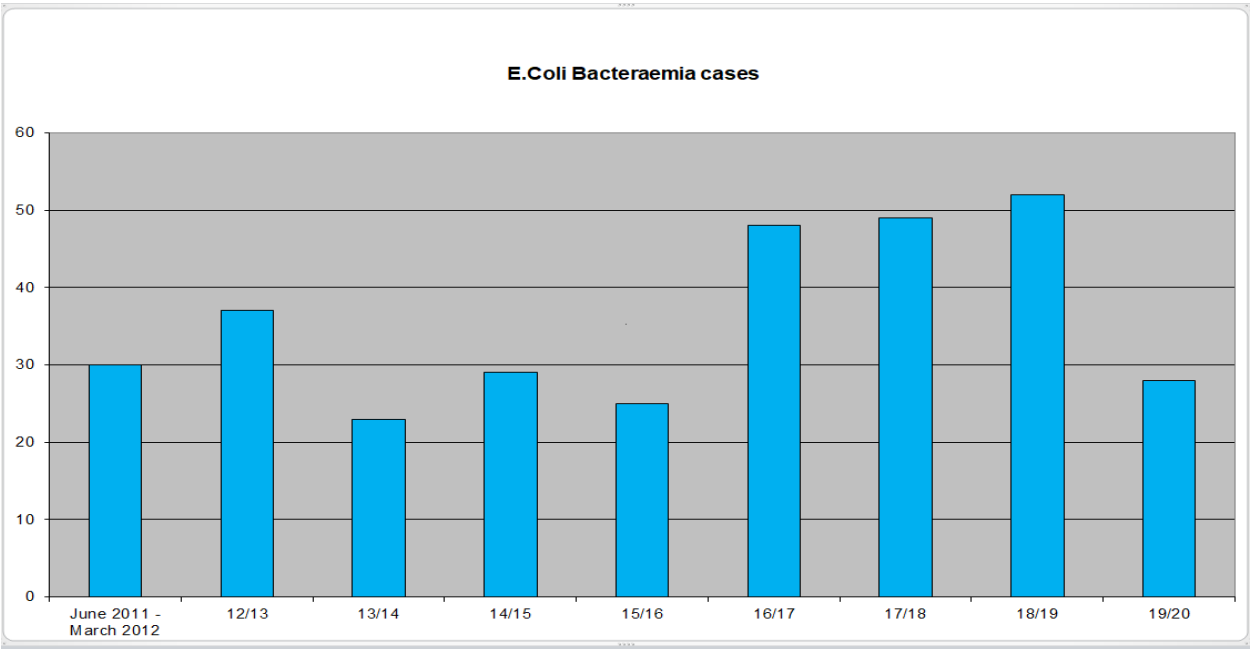
MSSA (Meticillin-sensitive *Staphylococcus aureus)* bloodstream infections are reported nationally although there are no mandated reduction targets set. 20 Trust apportioned cases were reported during 2019/20, compared to 16 the previous year. A review of these cases has been completed with recommendations included in the Trust's Infection Control Action plan.

The chart below shows the number of post admission MSSA bacteraemia.



E.coli Bloodstream Infections

There is aspirational national objective for the reduction of *E.coli* bloodstream infections for 50% reduction by 2024. We have seen a significant 56% reduction during the reporting period with a total of 28 cases in 2019/20, compared to 52 in 2018/19. There is a healthcare economy wide action plan which is being coordinated by Kirklees CCG to reduce *E. coli* bloodstream infections. Actions to support the reduction of *E. coli* bloodstream infections were incorporated in the HCAI (healthcare associated infection) action plan for 2019/20.

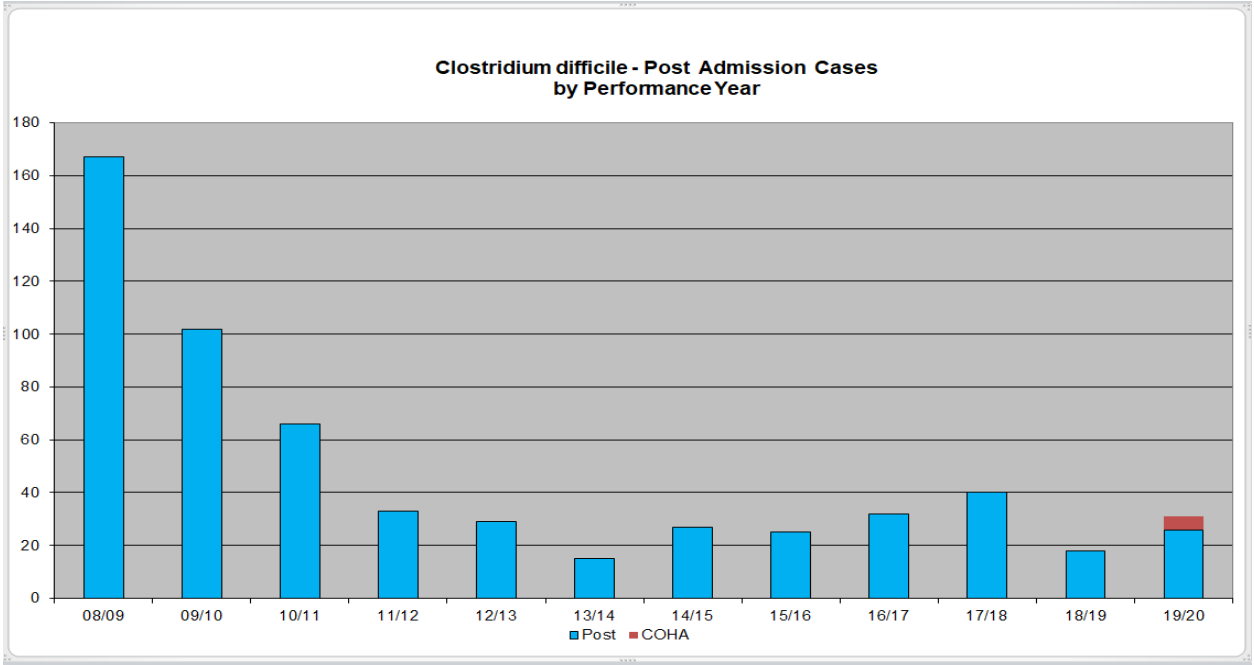


Clostridium *difficile* Infections

Changes to the national apportioning algorithm for 2019/20 meant that trust-attributable cases also included community cases that had been an inpatient at the reporting trust within the prior 28 days (now referred to as community onset healthcare associated COHA). The objective set for the Trust in 2019-20 was a ceiling of 40 cases: At the year end, we had 31 cases in total demonstrating an increase in cases from the previous year. All cases underwent an investigation following which 7 were deemed to have lapses in care identified; action plans for improvement were developed.

Key themes from the C. difficile cases identified at post-infection review are:

- Gaps in completion of the Bristol Stool Chart and assessing patient bowel habits
- Delays in isolation – wards awaiting specimen results before isolation as opposed to isolating patients at the time of sampling.
- Antibiotic prescribing is generally in line with policy, although inappropriate antibiotic prescribing including extended courses of antibiotics has been highlighted in a couple of cases. Antibiotics guidelines have been reviewed.



3. Serious Incidents and Outbreaks

The following incidents occurred in 2019/20 related to infection prevention and control.

- A cluster of *Serratia marcesens* was identified on Special Care Baby Unit at CRH. From August to November there were five cases of colonisations (2 of which were reported as having the same strain by DNA fingerprinting). This was reported and was managed as an outbreak. The actions included: - closing the unit, a deep clean of the environment using HPV, and an enhanced Serratia screening protocol, and both an internal/external review of clinical practice. Following these interventions, no further cases of Serratia have been acquired on the unit since December 2019.
- In January 2020 an incident arose in Endoscopy involving a stent that had lodged in a scope which was subsequently reprocessed and used on 3 further patients; patients were traced and followed up according to Trust policy. This was investigated according to Trust guidelines and involved PHE.
- MRSA cluster in a community nursing home, PHE-led investigation.
- Tuberculosis: There have been three in-patient exposure TB incidents that have required contact tracing. Staff contacts were referred to occupational health; patient contacts were traced and followed up according to Trust policy.
- Influenza: - From October 2019 to March 2020 there were 268 confirmed cases of Influenza compared to 380 the previous year, the majority of cases were Influenza A.. Point of Care testing (POCT)_ was available in both Emergency Department (ED) in from October, which aided patient management and flow.
- There was a national Outbreak of *Listeria monocytogenes* oin April 2019 involving nine in-patients deaths in total across several hospitals in England. There was confirmed

microbiological evidence linking all nine cases to sandwiches produced by one company and its meat products supplier who supplied sandwiches to 43 NHS organisations in England of which CHFT was one. The supply of sandwiches from this company was withdrawn across the Trust and an alternative supplier was sourced.

As a proactive measure Food hygiene standards were reviewed and monitored within the organisation including an inspection of the kitchens on both sites with relevant catering managers and IPC. The Food hygiene policy was reviewed and updated to reflect the provision and storage of sandwiches to wards and departments.

COVID-19 pandemic background:-

Containment phase; January 2020 – February 2020:- the national response to COVID-19 was the led by NHSE/I and PHE. The Trust was actively engaged from the beginning under the leadership of the DIPC/Chief Nurse/Chief Operating Officer, and Incident Management Team (IMT) was established that included key stakeholders.

The IPCT liaised with clinical colleagues in all emergency access areas to support and advise on:-

- The identification of potential isolation facilities across all emergency access areas, to manage cases of suspected COVID-19 who needed to be assessed.
- The initial installation and management of assessment PODs for testing members of the public who were suspected to have COVID-19
- Guidelines and training for staff on the use of Personal Protective Equipment (PPE) that were made available on the Trust IPC website.
- Identifying and supporting COVID-19 cohort wards and supporting and training staff.

Pandemic phase March onwards:-

As the situation rapidly moved into the pandemic phase the response was expanded and led by the IMT, the Trust contingency plans included: - escalation plans for additional capacity to manage patients who presented to be tested, review of potential isolation facilities and extending the programme for training staff to use enhanced PPE.

Several specific actions in response to the pandemic were undertaken by the IPCT these are summarised below:-

Implementation of National Guidance: - As the pandemic evolved there was rapidly changing national guidance from PHE supplemented by additional guidance from professional bodies. The IPCT interpreted national guidance to produce local Standards Operating Procedures (SOPS) for clinical staff including guidance on isolation/cohorting/collection and transport of high consequence infectious diseases samples.

There was close liaison with the microbiology laboratory to support in-house COVID PCR testing which helped improve the turnaround time of results substantially.

The IPCT consistently updated advice on PPE undertaking risk assessments and developing strategies to rise to the challenges of shortages in the national provision of PPE.

The IPCT provided expert advice and support to strategic and operational meetings that was incorporated into polices and daily communications. In additional, they also supported clinical teams from a wide range of specialities throughout each stage of the pandemic.

Training and education were key and the IPCT delivered bespoke presentation on the emerging coronavirus and the use of PPE; The team produced educational materials including video on donning & doffing PPE, posters and frequently asked question (FAQS) these resources were available on the trust intranet.

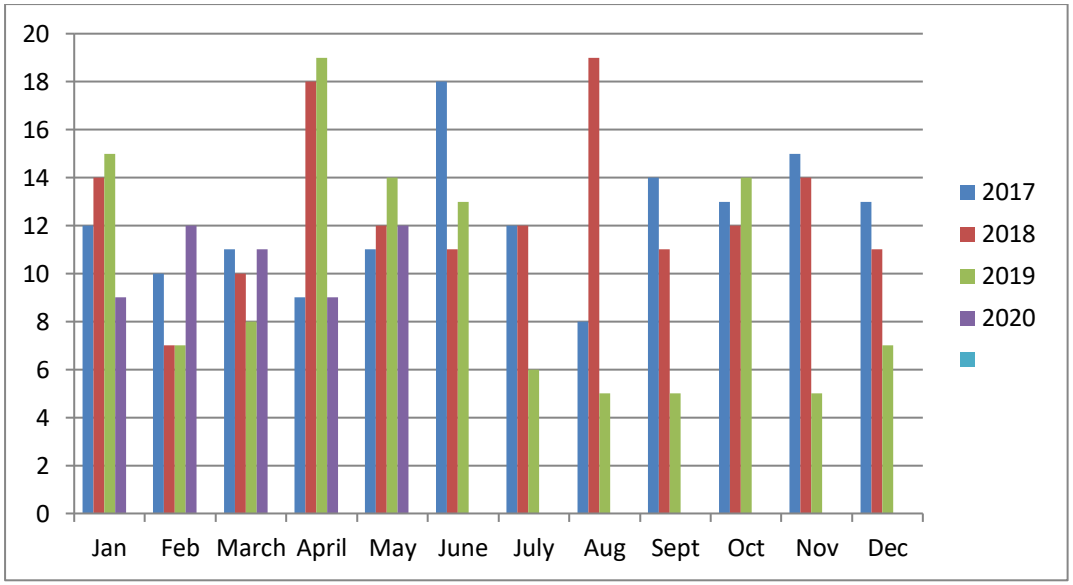
4. Occupational Health

Influenza – staff immunisation campaign 2019 - 2020
The NHS staff target uptake for 2019-20 was 80% of frontline healthcare workers to have had their flu vaccine by 28th February 2019, and demonstrable 100% offer. There was also a requirement for the Trust to collect and report to the department of Health on the number and reasons for vaccines being declined by staff.

A high profile campaign was launched in October 2019, and the final uptake of frontline healthcare workers reported to the Department of Health was 80.5%, this is an increase in the uptake from the previous year.

Contamination Risk Injuries to staff
A quarterly report is made to the Infection control committee of injuries reported to occupational health, and a small working group led by health and safety, interpret and follow up on learning from injuries to further reduce risks.

The following chart shows the year by year total of reported injuries to the OH Service, with an overall reduction noted during 2019 of sharps based incidents, believed to be attributed to increase competence in the use of needle safe devices.



Staff Hepatitis B immunisation

Following from international supply constraints of Hepatitis B vaccines, the staff immunisation gradually increased and immunisation of healthcare workers recommenced in October 2018 on employment and continued through 2019.

BCG immunisation

The OH service has continued to screen new healthcare workers for TB infectivity risks throughout this period, and is due to recommence immunisation of healthcare workers in higher risk areas.

5. Antimicrobial Prescribing

Antimicrobial stewardship is a program that promotes use of antimicrobials, improves the safety and quality of patient care, contributes to the reduction of antimicrobial resistance and decreases the spread of multi-resistant bacteria.

Antimicrobials Overview:-

Consumption:

Total Antimicrobial DDDs/1000 admissions per Quarter							
		Q1 average	Q2 average	Q3 average	Q4 average	Average of quarterly values YTD	% change on previous financial year
Financial Year 2017-18	CHFT	14256.12	5671.504	4690.37	5169.52	8205.999	
	NHS Yorkshire and Humber	5121.189	4912.539	5224.487	5528.195	5086.072	
	England Average	5477.694	5310.771	5500.816	5818.892	5429.76	
Financial Year 2018-19	CHFT	4746.68	4725.133	4694.89	4771.768	4722.235	-42.4539
	NHS Yorkshire and Humber	5186.389	5044.579	5340.608	5333.343	5190.525	2.053721
	England Average	5316.756	5096.948	5310.27	5272.617	5241.325	-3.47042
Financial Year 2019-20	CHFT	4676.146	4449.89	4817.001	4849.286	4647.679	-1.57882
	NHS Yorkshire and Humber	5200.238	5155.349	5454.05	5460.338	5269.879	1.528814
	England Average	5279.645	5140.044	5339.887	5495.943	5253.192	0.226419

Average quarterly values demonstrate a reduction in overall consumption for 2019/20 versus 2018/19 and highlight that as a Trust we are performing better than the regional and national average. Much work is to be done however to maintain this trend in light of the challenges faced from COVID-19.

CQUIN CCG1a (UTI) 2019-20

Aim: To improve the treatment and diagnosis of simple lower UTIs in patients over 65years in line with NICE and PHE guidance.

The target compliance is for 90% of all audited patients to comply individually with all four aspects of the CQUIN:

- Diagnosis according to PHE guidance

- No dipsticks to be used to diagnose UTIs in the over 65s
- Antimicrobials to be prescribed in line with NICE or Trust Guidance
- MSU sent to lab in line with guidance

Measure	Q1 overall	Q2 overall	Q3 overall	Q4
number of patients	75	76	75	
1 patient represents %	1.33	1.31	1.33	
Diagnosis % compliance	63	75	89	
Dipstick % compliance	23	66	85	
Abx choice % compliance	69	83	80	
MSU sent % compliance	73	80	83	
Overall % compliance	8	43	56	

Jan	Feb	March
19		
5.26		
89		
100		
74		
89		
63		

There has been a marked increase in overall compliance between Q1, Q2 and Q3.

Data from PHE shows that the majority of Trusts were scoring low across the country, with nobody achieving the CQUIN target in Q1. The average for England was 29% compliance. This reflects the scale of the challenge proposed by the CQUIN. On 11/10/19 it was announced that Q1 data would no longer be counted towards the CQUIN target.

Incomplete dataset for Q4 due to COVID-19 and CQUINs being suspended

Improvement Strategies

- Identified consultant and matron to work with AMT
- UTI guidelines mirror PHE for diagnosis and treatment
- Poster, screensaver, teaching to raise awareness of “ditch the dipstick”
- Introduced dipsticks that exclude markers of infection
- To dip or not to dip campaign well received
- Individual feedback to staff who were found to be non-compliant and to those performing well
- Moved from normal release (QDS to modified release (BD) nitrofurantoin
- Did a “Go See” in Nottingham to discuss challenges and interventions. Learning shared.

CQUIN CCG1b (surgical prophylaxis) 2019-20

Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines

Measure	Q1 overall	Q2 overall	Q3 overall	Q4
number of patients	41	57	81	
1 patient represents %	2.44	1.75	1.23	
Appropriate number of doses	90	93	99	
Appropriate antibiotics	93	86	95	
Overall % compliance	85	86	95	

Jan	Feb	March
21	17	
4.76	5.88	
95	94	
95	94	
90	94	

On track to meet target for Q4 however data collection suspended due to COVID-19.

Other work:

Gentamicin

- First line antibiotic in general surgery and urology within the trust.
- Pharmacy review of prescriptions, education of clinical teams, adaptation to gentamicin level selection within EPR, the development of prescribing resources (including advising on the gentamicin video) and negotiating additional phlebotomy support are some of the interventions put in place. A gentamicin prescribing re-audit was done In November 2019 and findings discussed at a gentamicin meeting with surgical colleagues in early February.
- AMT are currently in process of reviewing the gentamicin dosing and monitoring framework to a potentially simpler model.

Fluoroquinolones

- The trust antimicrobial guidelines are now hyperlinked to the safety advice for fluoroquinolones wherever these antibiotics appear within guidance.
- Multidisciplinary stewardship ward rounds focused on the appropriate use of these agents ran from Sept 2019 – February 2020.
- Supported junior doctor in a fluoroquinolone quality improvement project.
- Fluoroquinolone quality improvement project presented (as a poster) at NHS England's national annual IPC conference in Birmingham (February 2020).

CAP ward round

- Introduced a CAP antimicrobial stewardship ward round (June 2020) to focus on antibiotic prescribing (treatment choice and duration) and sampling.
- Working with The Health Informatics Service to develop new methods for data gathering to aid stewardship interventions.

Guidelines

- In addition to guidelines produced in response to COVID-19 the AMT have also made significant updates to GI infections, urinary tract infections, skin soft tissue infections, meningitis, and sepsis guidelines.

COVID-19

- Updated CAP guidelines in line with NICE rapid access guidelines and rolled out enhanced procalcitonin (PCT) testing for suspected/confirmed COVID-19 patients in whom concurrent bacterial LRTI was suspected clinically.
- Antimicrobial ward rounds for COVID-19 positive patients were implemented to review antibiotic usage in conjunction with PCT result.
- Currently auditing antibiotic use & PCT in COVID-19 positive patients
- Developed separate antimicrobial guidelines for the virtual frailty service to help in the response to COVID-19.

Public engagement

- A team from AMT, Microbiology lab and infection control developed and delivered an interactive educational event; 'House of Horrors' for the London Science Museum at the end of January as part of the 'Museum Lates' series. Selection was by a competitive process and sponsorship was secured from the Royal College of Pathology.
- Antibiotic awareness week. The AMT worked with IPCT colleagues to develop, promote and run stands across the trust promoting appropriate IPC and antimicrobial use. Our 'pledge hedges' were pivotal in engaging staff and the public and received almost 1000 pledges from participants who considered their role in IPC and antimicrobial use . Materials were provided to engage children, patients and visitors; and messages were placed on screensavers and in Trust news. The AMT also ran an allergy status audit during the week.

Proactive working

- Antimicrobial webpage has been adjusted to increase accessibility
- Consultant champions have begun to be appointed to increase engagement with AMT
- Plan to develop an antimicrobial dashboard

6. Decontamination

There was a refresh of the Decontamination services following the retirement of the Decontamination manager in November 2018. The provision of the role was support by the decontamination from Airedale Hospital 1 day per week From June 2019 to the present time.

During the reporting time period external audits of both Endoscopy units were undertaken by the external authorised Engineers with excellent results for both sites. A Gap analysis was performed and Standard Operating Procedures were updated.

Decontamination of re-usable Tonometer Heads underwent a review and following risk assessment by IPCT and the decontamination manager the recommendation was made to change to single use disposable tonometer's was approved.

The Decontamination Committee was reinstated in November 2019 and is chaired by the surgical divisional director of Operations.

7. Cleaning Services

The Trust cleaning services are provided by CHS (CHFT Partner) at HRI and ISS (PFI partner) at CRH.

As part of the monitoring arrangements both companies self-monitor the performance of cleaning services against key performance indicators. These are reported to the Trust on a monthly basis for analysis and challenged where appropriate by the Service performance team and via escalation to the IPCT.

In addition, the standard of cleanliness was monitored fortnightly by the ward/dept manager as part of the FLO (frontline ownership) audits which forms part of the assurance framework.

The IPCT works in conjunction with the Estates and facilities team, clinical divisions, and PFI partners to ensure cleaning standards are met across the Trust.

All new employees attend a generic induction with additional bespoke IPC training.

8. Estates

The IPCT continue to advise and support estates with refurbishments within the Trust. This has required attendance at key design and planning meeting and the review of plans to ensure they meet minimum build standards.

Water sampling for *Legionella* and Pseudomonas was undertaken in accordance with L8 and health technical Memoranda (HTM-04). Any remedial action was successfully undertaken on outlets that did not meet the required standard.

Annual performance and verification checks were undertaken on all critical ventilation systems including theatres revalidation.

Patient-led Assessments of the Care Environmental (PLACE) were undertaken during September and October 2019 a summary of the scores are below:-

Category	Percentage CRH	Percentage HRI
Cleanliness	99.3%	98.83%
Food	92.16%	90.45%
Organisational Food	94.44%	96.67%
Ward Food	91.62%	89.05%
Privacy, Dignity & Wellbeing	92%	93.43%
Condition, Appearance & Maintenance	99.35%	98.16%
Dementia	80.11%	84.92%
Disability	86.07%	85.80%

9. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2019/20:

Section A	Infection Control Arrangements Policy
Section J	Multi Resistant Organisms
Section Y	Control and Management of Clostridium difficile

10. Education and training

A blended learning approach continues with the provision of both face to face and e-learning for clinical staff.

Since the COVID pandemic was declared face to face training has been kept to a minimal ensuring social distancing is maintained. Level 2 IPC training is now e-learning and will remain as this going forward with bitesize and bespoke training session arranged as required.

In addition education is provided on a one to one basis during routine clinical visits by the IPCNs and in response to patient specific clinical enquiries from wards and departments.

The IPCT also support Aseptic Non Touch Technique (ANTT) training, supporting compliance and safety metrics and zero harm; the Trust overall compliance at the end of March 2020 reported 84%.

Comprehensive Infection prevention training for the Junior doctors induction day, including the assessment of ANTT.

The IPCT has led FIT testing for FFP3 masks has been supported throughout the year and a strategy for delivering this is a more sustainable way is being reviewed, this includes the provision of personal issue reusable masks for those staff working in high risk areas.

The IPCT keeps update to date with current national policies and guidance and attending any relevant study days or conferences.

11. Conclusion

The content of this report reflects the breadth of activity and enthusiasm to constantly improve and develop new and innovative ideas for improving and maintaining patient safety. The IPCT has developed a reputation for effective prevention and management of infection Prevention and Control despite the challenges posed during the reporting period.

Appendix 1:

Link to the Infection Prevention & Control Arrangements Policy:

http://www.cht.nhs.uk/services/clinical-services/infection-prevention-and-control/infection-control-policies/

3. Safeguarding Update Annual Report Adults and Children

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	3 September 2020
Meeting:	Board of Directors
Title of report:	Safeguarding Children and Adults Annual Report 2019/20
Author:	V Thersby, Head of Safeguarding L Rudge, Deputy Director of Nursing
Sponsor:	E Armistead, Executive Director of Nursing/ Deputy CEO
Previous Forums:	Quality Committee 2 September 2020

Actions Requested:

To note.

Purpose of the Report

This Annual Report provides an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust.

The report provides assurance to the Board of Directors highlighting key performance activity and information of how its statutory responsibilities are being met, and of any significant issues of risks, and how these are mitigated.

Key Points to Note

- CHFT has met its statutory, regulatory and contractual obligations ensuring that statutory posts have been filled throughout the year.
- CHFT has met its statutory responsibilities in relation to PREVENT
- Adult Safeguarding has seen an increase in referrals that meet the section 42 criteria of the Care Act 2014 made by CHFT staff into the multi-agency policies and procedures; The continued number of referrals provides assurance that there are robust reporting arrangements in place and that staff are aware of safeguarding procedures..
- The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The Minister of State announced post pandemic that they now aim for full implementation of LPS by April 2022,
- CHFT and SWYPFT have continued to work in partnership formally through the Service Level Agreement, the scheme of delegation and the joint clinical working protocol. CHFTs Mental health Operational Group and Safeguarding Committee receive data and assurance that our MHA processes are robust and effective.
- CHFT are fully compliant with the National Mortality Review Programme (LeDeR) and have taken part in NHSI LD standards pilot data collection in 2019 and 2020
- CHFT have maintained mandatory reporting in relation to Prevent and FGM. These training figures have maintained above 90% compliance.

- Nationally there are concerns regarding the impact of the restrictions in place since March 2020 and how this will impact in relation to increased and unseen domestic abuse. The Safeguarding team responded to concerns raised by the Government and have disseminated information, and created a safeguarding Covid-19 intranet page whilst maintaining the service throughout the pandemic.

- The Calderdale's Children Looked After team sent every 18-25 years old care Leaver a letter at the start of the Lockdown offering advice and support and how to contact the team, with up to date public health information was shared including advice around handwashing etc.

- Safeguarding training is a mandatory requirement for all staff. Whilst overall compliance compared to last year remains stable and above 90%; level 3 safeguarding adults and Children's training did not reach the Trust target of 90% by March 2020 (this has now been achieved as of June 2020)

EQIA – Equality Impact Assessment

Equality impact assessment forms the basis of much of the work of the Safeguarding Team. The role of the team is to ensure that those in the most vulnerable groups are protected from harm.

The team will continue to ensure equality in accessing services for those from protected characteristics.

Recommendation

The Board of Directors is asked to receive the Safeguarding Children and Adults Annual Report for 2019/2020 and note the key highlights and the priorities for 2020-2022 described in the Safeguarding Strategy attached as Appendix 1 to the annual report.

compassionate care

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Safeguarding Annual Report 2019-2020

FOREWORD

Safeguarding is a statutory responsibility of all NHS organisations as detailed under the Care Act (2014), and the Children Act (1989/2004). Legislation and guidance are built upon the principle that the welfare of the most vulnerable in our society is paramount and that all statutory services consider and promote the needs of children, families and adults at risk.

Calderdale and Huddersfield NHS Foundation Trust (CHFT) is committed to ensuring that safeguarding its patients, staff and the wider community is given the highest priority in all that the Trust does.

Safeguarding work across the Trust is underpinned by CHFTs values by demonstrating our behaviours, known as our four pillars

- putting patient's first,
- we go see,
- we do the must-do's
- we work together to get results.

Safeguarding is an integral part of core business and is a shared responsibility. We work together with multiagency partners across the Districts of Kirklees and Calderdale to improve the lives and protect the most vulnerable in our society from harm.

CONTENTS

INTRODUCTION

The 2019-2020 annual report provides the Trust Board with an overview of the national and local context of safeguarding and areas of practice included in safeguarding across the Trust. The report will show performance activity and inform the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks, and how these are mitigated. The Safeguarding strategy as part of this report will describe priorities for 2020-22 (appendix 1).

This report is a combined Children and Adults Safeguarding Report that describes all areas of safeguarding activity. The report describes how the Children and Adults Safeguarding Team work together across the trust and demonstrates to the Trust Board and external agencies how Calderdale and Huddersfield NHS Foundation Trust discharge its statutory duties in relation to:

- The Mental Health Act (1983)
- The Children Act (1989)
- The Sexual Offences Act (2003)
- Female Genital Mutilation Act (2003)
- Children Act (2004) - Statutory duty to make arrangements to safeguard and promote the welfare of children under Section 11
- Domestic Violence and Victims Act (2004)
- The Mental Capacity Act (2005) and Deprivation of Liberty Safeguards amendment in 2007
- Registration standards, Health and Social Care 2008 (Regulated Activities) Regulations 2014: Regulation 13
- CQC national standards of quality and safety - Outcomes 7-11: Essential standards of quality and safety
- Safeguarding Vulnerable People in the NHS- Accountability and Assurance Framework (2013)
- Care Act (2014)
- Counter- Terrorism and Security Act (2015)
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (First Edition: August 2018)
- Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (Fourth edition: January 2019)
- The Coronavirus Act 2020

GOVERNANCE ARRANGEMENTS

All staff have a statutory responsibility to safeguard and protect those who access our care regardless of their position in the Trust. However, some defined named safeguarding roles exist for safeguarding.

- The Executive Lead for Safeguarding Children and Adults is the Executive Director of Nursing, this responsibility is delegated to the Deputy Director of Nursing.
- The Safeguarding Team and Named and Designated Professionals provide both strategic support and direction to the governance and safeguarding arrangements within CHFT, and operational advice and support to all trust staff.

    - The Trust has in place a Named Doctor for Safeguarding Children, a Named Midwife, a Named Adults Professional and Named Nurses for Safeguarding Children.
    - Designated Doctors for Safeguarding Children and Looked After Children are employed by CHFT, and as well as their Trust roles also attend the Local Safeguarding Children Partnerships as part of their Designated role.
    - The Trust attends the Local Child Death overview panel meetings with representation from the SUDIC Paediatrician and midwifery service.

Our internal arrangements ensure that Safeguarding remains core Trust business. More formally the Safeguarding Operational Group attended by representatives from all divisions reports directly to the Safeguarding Committee which meets bi-monthly. This Committee reports into the Quality Committee. Direct alignment to the Trust Board ensures clear lines of reporting and accountability.

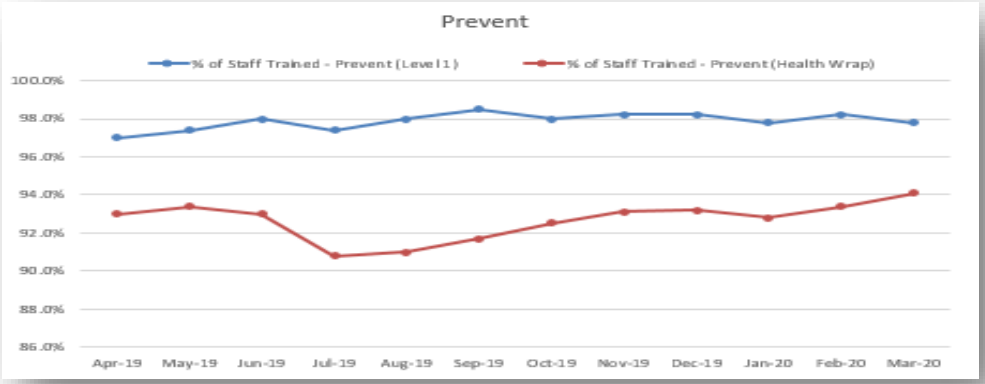
PREVENT

The Counterterrorism and Security Act (2015) places a duty on CHFT to have; *'due regard to the need to prevent people from being drawn into terrorism.'*

CHFT have met its statutory responsibilities in relation to ensuring

- Prevent training is delivered in line with the Prevent Competencies Framework (2017)
- The Policy is in place in the Trust.
- Quarterly Prevent data is submitted.
- Partnership links with Local arrangements and meetings are attended.
- Fulfilling the requirements of the NHS Contract.
- Prevent leads are in post.

*Graph show increase over past year of both Levels of Prevent training



Key Achievements

- PREVENT Policy reviewed and describes how the PREVENT Strategy is implemented in CHFT.
- The Trust Safeguarding Committee receives a quarterly update regarding PREVENT, and quarterly updates sent to NHSE.
- CHFT Safeguarding Team provides representation at Channel panel within the local district.
- PREVENT training remains consistently above 90%.

Priorities in 2020-21

- Consider implementation of new PREVENT training programme once released by the Home Office.
- Increase the number of PREVENT champions

ADULT SAFEGUARDING

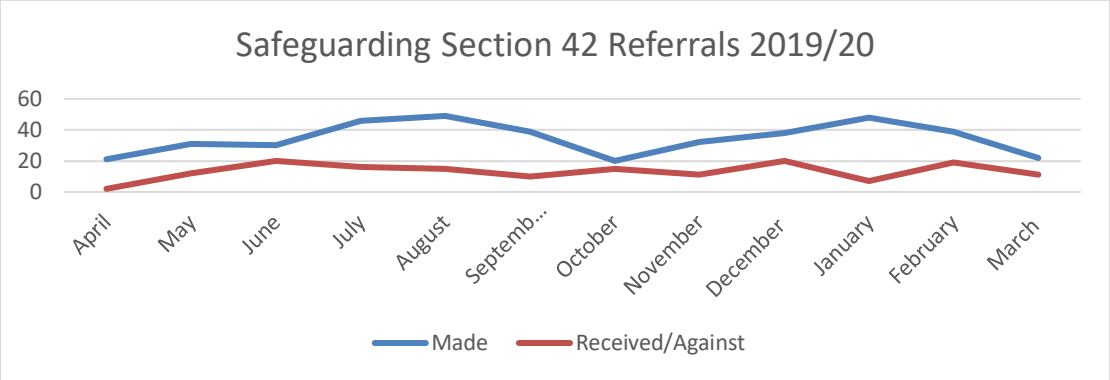
Following the introduction of the Care Act (2014) implemented in April 2015; adult safeguarding has been on a statutory footing. CHFT has met our statutory, regulatory, and contractual Safeguarding Board requirements and obligations, by ensuring there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

There has been continued commitment from the Safeguarding team to attend and contribute to the local authority partnership safeguarding board subgroups as well as participating in multi-agency audits where appropriate. The Deputy Director of Nursing and Head of Safeguarding attend the strategic boards for Calderdale and Kirklees.

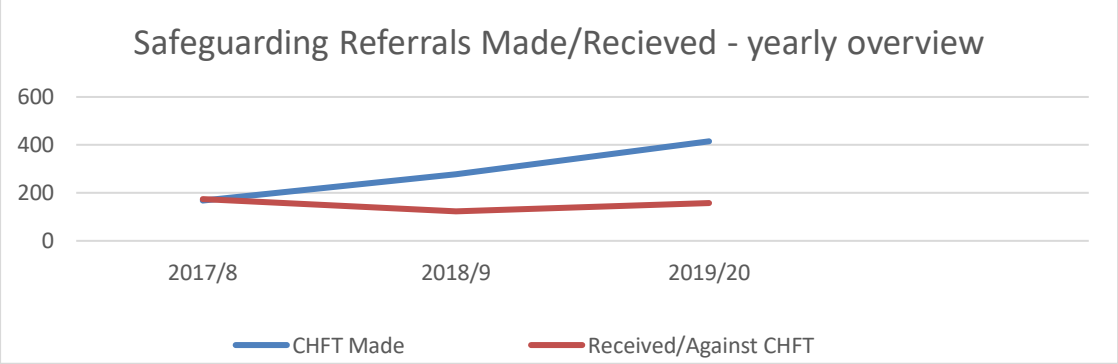
Data Summary

The data below indicates the referrals that meet the section 42 criteria of the Care Act and submitted to either Kirklees or Calderdale Gateway to Care.

Section 42 referrals



Safeguarding referrals made or received by CHFT



**advice calls to the team are not recorded as part of this data.*

- There were a reduction in referrals made in March 2020 is in line with the reduction in hospital attendances during Covid 19.
- No identified reason for the dip in referrals made in October 2019 – November 2019 and/or the spike in referrals for both August 2019 and January 2020.
- The overall increase is likely linked to the effectiveness training and awareness Trust wide.
- A significant increase overall in the number of referrals made by CHFT into safeguarding procedures year on year.
    - 2017-18 to 2018-19 – a rise of 66%.
    - 2018-19 to 2019-20 a further rise of 49%.
- Overall there has been a reduction of safeguarding referrals and concerns made against CHFT.
- The continued high numbers of all referrals provide assurance that there are robust reporting arrangements in place, and staff are aware of safeguarding procedures.
- The largest category of abuse identified is recorded under the 'neglect' heading; further analysis of this category identified that discharge from hospital was involved.

Key achievements 2019 – 20

- Safeguarding Adults Policy updated in line with the new West, North Yorkshire and York Multi- Agency Safeguarding Adults Policy and Procedures.
- Developing the network of Safeguarding Champions on wards and departments.
- Maintained attendance to Safeguarding Board and Subgroup meetings.
- Updated the Safeguarding Intranet Pages.
- Developed flow charts for ward and departments to follow when safeguarding concerns are identified, including 7-minute briefings.
- Updated the Allegations Policy to include reference to PIPOT (Persons in a Position of Trust); guidance issued by the Safeguarding Adults Board.
- Reviewed training in line with the Adult Intercollegiate Document.
- Promoted the West Yorkshire Police online portal for Trust colleagues to report any intelligence and information around possible criminal activity and any other safeguarding matters such as CSE, CCE and FGM.

Priorities in 2020-21

- Continue to embed 'Making Safeguarding Personal' and work with partners to put patients at the heart of what we do by embedding this culture.
- Work with adult social care to ensure that referrers receive feedback from concerns raised, and a consistent approach to referral thresholds is achieved.
- Embed staff knowledge and understanding relating to falls and referrals into safeguarding procedures.
- Continue being involved in Discharge Improvement work.
- Review the Missing Persons Policy.
- Contribute to the Was not Brought Policy for Children in relation to Adults.
- Develop the Adults Supervision Policy and implement a supervision and implementation strategy for the Trust

SAFEGUARDING WEEK (CHILDREN AND ADULTS) AND OTHER PROMINENT DAYS

Multi-agency partners across West Yorkshire came together as part of Safeguarding Week to raise awareness about abuse and safeguarding issues. In June 2019 the safeguarding team worked with both Calderdale and Kirklees Safeguarding Adults Board and Safeguarding Children Partnership in planning and promoting the week.

In Calderdale the theme was **'See me, hear me, know me- make safeguarding personal'**, and across Kirklees the theme was **'Safeguarding - It's everyone's business'.**

Key Achievements

- As a key partner and part of West Yorkshire's events CHFT's safeguarding team collaborated with Calderdale Safeguarding Adults Board and Safeguarding Children Partnership in planning and promoting the week.
- In CHFT the team presented a display to promote this and disseminated key messages and events available.

Priorities 2020-21

- To work with Calderdale and Kirklees partners to promote safeguarding week in 2020.

LEARNING DISABILITY

At CHFT we support staff to have an understanding of the needs of people with a learning disability to ensure they can support reasonable adjustments to ensure the same access to health care as everyone else. This is a mandatory requirement under the Equality Act (2010). To meet these requirements CHFT employs a full time Matron Lead for Learning Disabilities who has strategic responsibility for implementing national guidance, provide support and advocacy to inpatients on adult ward, support in outpatients when needed regarding clinical decision making, and support with the Mental Capacity Act and best interest decision making.

Learning disabilities is reported to the Trust Board via escalation from Quality Committee from its subgroup structure which includes the Patient Experience and Caring Group, Safeguarding Committee and Mortality Surveillance Group.

The Safeguarding Committee receives several reports including patient's subject to Deprivation of Liberty (DoLS), when we have instructed an Independent Mental Capacity Advocate (IMCA) for serious medical treatment, and safeguarding referrals made by the Trust to Gateway to Care.

Key Achievements

- Fully compliant with the National Mortality Review Programme (LeDeR).
- The learning disability improvement standards launched in June 2018 by NHS Improvement - CHFT took part in the pilot data collection for the National Standards in 2019 and again in 2020.
- Reasonable adjustment audit undertaken for all admissions.
- CHFT signed up to take part in the first phase of Royal Mencap's Treat me well campaign.
- CHFT took part in the first NHSI Transition collaborative which started in May 2019.
- An easy read patient survey was undertaken twice a year to gather feedback from people with a learning disability.
- CHFT have adopted the **THINK LD Campaign** approach and have given out badges and posters during learning disability week in June 2019.
- All our patients with a learning disability have their records flagged.

Priorities 2020-21

- Production of a training film by the Treat me well group.
- Continue to work alongside the Treat me well campaign group to ensure the voices of people with learning disability are heard and they are involved in transformation of future services to meet these needs.

PRESSURE ULCERS

The Tissue Viability Service is nurse led providing specialist advice and care to patients with, or at risk of developing complex and hard-to-heal wounds. One of the priorities of this service is to reduce pressure ulcers and patient harm. The Tissue Viability service has prioritised pressure ulcers and moisture associated skin damage as key areas for quality improvement and reduction in harm.

'Pressure Ulcers and the interface with a Safeguarding Enquiry: When to raise an Adults Safeguarding Concern' (DH 2018), provides a framework to identify if a pressure ulcer requires a safeguarding enquiry. This requires the completion of a decision tool which determines the need for a safeguarding referral to Gateway to Care.

- This was approved by the Safeguarding Committee and shared with external organisations including Calderdale CCG and Calderdale Safeguarding Adults Board. The tool was embedded within the Trust's Datix system.

Key Achievements

- A new Tissue Viability Service Operational Policy was developed; this includes guidance in relation to referring patients with any safeguarding concerns to the Tissue Viability service.
- A new Moisture Associated Skin Damage Policy developed and currently in consultation with stakeholders.
- A multi-professional Patient Concordance Task and Finish Group has been developed following a review of incident themes.
- A review of both hospital and community pressure ulcer electronic patient records has taken place.
- A suite of clinical pressure ulcer prevention and management reference tools have been developed and issued to all community nursing teams across the Trust.

Priorities 2020-2021

- Embed areas of progress and evaluate the effectiveness through the Safeguarding Operational Group.
- Ensure consistency of decision support tool usage and reporting on the datix system.
- Audit incidents referred to Gateway to Care to determine if the Decision Tool was used.
- Explore feasibility of building a dedicated pressure ulcer-related safeguarding questionnaire into Datix.
- Standardise root cause analysis tool including 48-hour rapid review ensuring consistent approach across divisions
- Revise the Trust Pressure Ulcer Policy to ensure it aligns with national guidance and best practice including more complex clinical scenarios.
- Continue to strengthen the output of the Pressure Ulcer Collaborative through multi-professional and multi-partnership working.

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009). The Mental Capacity and Deprivation of Liberty Policy is currently in date and MCA DoLS training is delivered as part of the essential skills framework approved by WEB. The Safeguarding Team are the point of contact for advice and support in relation to MCA and advice calls.

The Safeguarding Team continues to work closely with DoLS managers for Calderdale and Kirklees to support consistency of applications across the CHFT footprint.

DOLS applications

Year	Number of Urgent DoLS	Number Standard DoLS	Number Declined	Average p/month
2014/15	11	5	0	0.9
2015/16	194	33	11	16
2016/17	369	50	212	31
2017/18	324	42	242	27
2018/19	219	27	192	18
2019/20	186	20	166	15

**These figures suggest that despite a decrease in applications overall there is a positive level of awareness and recognition of patients who may fall within the ACID test for DoLS.*

Key Achievements

- DoLS data is recorded and shared at the Safeguarding Committee meeting.
- Continue to monitor all patients who are subject to an urgent or standard authorisation.
- Notifications are sent to CQC of all DoLS authorisations in the Trust.
- MCA and DoLS training delivered as part of the essential skill framework for staff at levels 1-3.
- Continued work embedding knowledge and skills in all areas regarding MCA/DoLS.
- 87% of applications are made by the ward.
- Training regarding MCA/DoLS and Mental Health to maternity services has been written into the annual training for midwives delivered by the Named Safeguarding Midwife.
- Significant improvements made to the quality of DoLS submitted (only 33% of referrals required minor amendments).

Priorities 2020-2021

- To continue to support wards in completing their own DoLS applications
- The implementation of the MCA template into Cerner and Athena Systems.
- To continue to support staff to embed MCA into practice
- To monitor closely the progression of the Bill and link with other Local NHS Trusts around implementation and plans for embedding.
- Work with legal services department to ensure plans for new systems are embedded.
- Review the MCA DoLS Policy.

MENTAL CAPACITY (AMMENDMENT) BILL

Background

The Mental Capacity (Amendment) Act received Royal Assent in May 2019 and introduces the Liberty Protection Safeguards to replace DoLS. The purpose of the Bill is to provide a simplified legal framework and authorisation process which is accessible, clear, deliver improved outcomes for people deprived of their liberty and place the person at the heart of decision making.

The Minister of State announced post pandemic that they now aim for full implementation of LPS by April 2022. Some provisions, covering new roles and training, will come into force ahead of that date.

Implications for CHFT

- Hospitals (the responsible body) will be responsible for authorising the deprivation of liberty (it will no longer be the Local Authorities responsibility, but the Hospital Manager.
- Referral pathways and authorisation process will need to be considered.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
    - The person lacks capacity to consent to the care arrangements
    - The person is of unsound mind
    - The arrangements are necessary and proportionate

  All 3 of the above criteria must be met

- The deprivation can be used in a variety of settings (i.e.) those who live at home and have respite care and a day centre.
- Staff will need to be trained and aware of what the new Liberty Protection Safeguards constitute as well as what an objection is including how to refer to an Approved Mental Capacity Practitioner (AMCP) – acting as a form of mediation prior to a Court of Protection Appeal.

Priorities 2020-21

- Consider implications for CHFT Acute and Community Services once the public consultation commences regarding to MCA and DoLS codes of Practice.
- Provide detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice.
- Review Trust Safeguarding Team resources to implement the new LPS scheme including training, new processes, and expertise.

MENTAL HEALTH ACT

CHFT have continued to work in partnership with SWYPFT over the last 12 months formally though the service level agreement (SLA), the scheme of delegation and the joint clinical working protocol. This service level agreement formalises partnership arrangements between both Trusts and ensures that CHFT are compliant in fulfilling their statutory duties.

The Safeguarding Lead (CHFT) attends SWYPFT Mental Health Act (MHA) Committee meeting and the Lead for the Mental Health Act (SWYPFT) is invited to and receives the minutes of the Safeguarding Committee meeting. Copies of all MHA Committee papers are made available to the CHFT Safeguarding Lead and the Safeguarding Committee. CHFT and SWYPFT partners meet regularly at CHFT's Mental Health Operational Group.

The Mental Health Liaison Team (MHLT) support and work with CHFT Trust staff to ensure that all patients who are referred are reviewed and supported in a timely way. There is continued support by the safeguarding team liaising with the MHA Office to ensure MHA section papers are scrutinised, reporting mechanisms for CHFT patients is fulfilled, and statistical information is shared by SWYPFT. The Safeguarding Team continue to support the facilitation of tribunals and hospital managers hearing as requested.

	2017 -18	2018-19	2019-20
Section 5(2)	6	10	11
Section 2	25	21	23
Section 3	6	3	3
Tribunals	0	2	1

** Statistical information regarding the use of the MHA within CHFT is made available to the Safeguarding committee meeting every month. This data has been stable over the last 2 years*

Key Achievements

- The process for implementing MHA Sections within CHFT has been reviewed and agreed with SWYPFT Mental Health Liaison Team and MHA Office to ensure robust oversight of all Section 5(2), Section 2 and Section 3 detentions at CHFT.
- Facilitated receipt and scrutiny training sessions delivered by SWYPFT staff.
- Raising awareness through bite sized learning that processes are followed correctly when using the Act.
- The 'Hospital Managers' for the purpose of MHA reviews all had personal annual reviews as required by MHA code of practice. These were undertaken by a Non-Executive within SWYPFT.
- Established a Mental Health Operational Group involving SWYPFT partners.

Priorities 2020-2021

- Update the Joint Protocol in line with the CAMHS Out of Hours Working Arrangements
- Continue to facilitate 'Receipt and scrutiny' training for staff who will accept Section papers on behalf of CHFT.
- Complete the CHFT Mental Health Policy.

SAFEGUARDING MENTAL HEALTH AND MIDWIFERY

CHFT continue to work in partnership with SWYPFT and Locala, to provide care for pregnant women who have mental health concerns. The Clinical Lead for Perinatal Mental Health (PNMH-Midwifery Services), supports women and families with mental health difficulties in the antenatal and post-natal period. The PNMH Clinical Lead provides case supervision, consultation and advice to midwives and obstetric colleagues within the acute Trust and community setting regarding PNMH issues.

High risk women with a diagnosed mental illness, such as bipolar, schizophrenia, previous puerperal psychosis and/ or severe depression are referred to the Specialist PNMH Team (SWYPFT) for close partnership working. Mental ill health, both in the ante natal or post-natal period can have a negative impact upon the attachment between the mother, baby and family unit, which may result in safeguarding issues.

The Clinical lead for Perinatal Mental Health (PNMH) works closely with the Named Midwife (Safeguarding), and the Substance Misuse Specialist Midwife. This promotes greater multi - agency working and enhances the care provided for women with severe mental health difficulties. PNMH care plans are developed for high risk women (between 28-32-week gestation), in collaboration with SWYPFT, Midwifery and Health Visiting services, and in partnership with the woman and her family; these care plans further safeguard the woman and baby. CHFT Midwifery services have a close partnership working with SWYPFT Mental Health Liaison Team (MHLT), whom frequently review and assess women's mental health following birth and prior to discharge home from CHFT.

Key achievements

- A joint ante natal clinic involving the Perinatal Clinical Lead, Lead Obstetrician for Perinatal mental health and the PNMH Team Psychiatrist has recently been developed.
- The PNMH Clinical Lead co facilitates Multi Agency PNMH Awareness Training with co facilitators from the PNMH Team and Locala Health Visiting services.

Priorities 2020-21

- To identify SMART outcome measures for this cohort of women – with guidance also from the LMS / Regional PNMH Steering group.
- Co work with the Name Midwife to complete and disseminate the quick glance Safeguarding Guidance Tool incorporating PNMH guidance.
- Continue to raise awareness amongst maternity staff to utilise /embed the Calderdale Safeguarding Partnership - Assessing Impact of Parental Mental Health on Children and Young People Tool.
- Review the impact that Covid 19 Pandemic has had upon the emotional wellbeing of pregnant women and mental health services available to them and disseminate any digital / virtual resources amongst maternity staff and service users.
- To evaluate the effectiveness of PNMH Multi Agency Awareness Training and identify future learning requirements.

CHILDREN AND YOUNG PEOPLE

CHFT is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children - 2018,'the Children Act 1989/2004 and to joint working with both the Calderdale and Kirklees Safeguarding Children Partnerships. The Trust works within the West Yorkshire Safeguarding Children Policies and Procedures for the protection of all children who attend CHFT.

CHFTs' safeguarding responsibilities are effectively discharged by the provision of day to day advice, supervision, support and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and child practice safeguarding/ learning lessons reviews.

Performance Data Children

Incidents Reported on Datix	2016 - 2017	2017-2018	2018-2019	2019-20
Child Safeguarding Concerns	56	52	76	53
Child Safeguarding Referrals	22	17	25	16
TOTAL	**78**	**69**	**101**	**69**

**Children's data is recorded in several different formats and shared with the Safeguarding Children Partnerships via the multi-agency Health Advisory Implementation Groups.*

Key achievements

- Delivered bespoke safeguarding supervision to support staff achieving compliance with their mandatory requirements.
- Facilitated supervision training to increase the number of supervision facilitators.
- Developed a 7-minute briefing and SOP in relation to the BBS protocol to support staff following agreed safeguarding process.
- Worked closely with the Safeguarding Children's Partnerships and key agencies in fulfilling the Trust commitment to multi-agency working.
- Attended regional/ national named professional safeguarding meetings to ensure safeguarding practice in CHFT is informed.
- Benchmarked safeguarding practice with other local and national trusts
- Disseminated safeguarding updates and key messages Trust wide via the safeguarding team virtual notice board, 7-minute briefings and the safeguarding intranet page (these have included briefings on ACE's, Lived experience of the child, safer sleeping, supervision).
- Flags /alerts are added to all patient records where required - in complex cases this includes a safeguarding management plan.

- Collaboratively worked with both Kirklees and Calderdale's Local Authorities 'front door' services ensuring that if they receive any poor-quality referrals made by CHFT that the safeguarding team are notified.
- Attended complex safeguarding cases MDT meetings.
- Worked collaboratively with the Risk Department to develop effective processes to record actions and disseminate learning.
- Worked with the Risk Department regarding requests for Court statements.
- Developed a risk assessment and care plan for children with mental health needs.
- Developed a process for documenting safeguarding issues on the electronic patient record.
- Reviewed the Paediatric Liaison role and developed a SOP.
- Developed a practice briefing in relation to COVID 19.
- Escalated to NHSE that the level 1 national package does not meet the intercollegiate document (2019) requirements.
- Maintained availability of the level 3 safeguarding children training package though Covid 19.
- Contributed towards the development of the Consent Policy.

Priorities 2020-201

- Continue to embed and provide safeguarding supervision.
- Develop the Safeguarding Champions role and look at different ways of engagement.
- Electronic Paediatric Liaison referral process to be operationalised (delayed due to COVID 19).
- The under 18/ vulnerable adult safeguarding proforma is being built into EPR for wider use throughout the Trust.
- Launch the new Level 2 e-learning training package.
- Review level 3 safeguarding children training offer.
- Implement the new 'Care of a Child/ Young Person with Mental Health Needs' Policy.
- Develop a new 'Was not brought Policy' in relation to missed appointments.
- Update the Supervision Policy.
- Continue to ensure that the Safeguarding Children team have overview of all referrals made to children's social care by departments and ward areas though training, supervision and awareness raising.
- Work with the Health Assurance Subgroups of the Childrens Partnerships to share information and data as requested though this group.

CONTEXTUAL SAFEGUARDING

Contextual Safeguarding is an approach to understanding young people's experiences of significant harm beyond their families and recognises the impact of the public and social context on young people's lives, and consequentially their safety. It seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or young people. This can include CSE, peer or peer violence, abuse, modern day slavery, harmful sexual behaviour, abuse in gangs and groups, criminal exploitation and going missing from home or care; should not be seen in isolation as they often overlap, creating a harmful set of circumstances and experiences for children, young people, families and communities.

The safeguarding team works closely with our local partnership arrangements in developing local protocols and working in partnerhsip to esure how individual cases are managed locally.

Key Achievements

- Attended the Kirklees Exploitation Subgroup and MACE meeting; and the Child Criminal Exploitation meeting in Calderdale.
- Young people at risk of CCE/CSE are flagged on the electronic patient record system.
- Contextual safeguarding is included in level 3 safeguarding children training and bespoke ED safeguarding training.
- Developed an under 18/ vulnerable adult safeguarding proforma which includes contextual safeguarding.
- Ensured that at risk pregnant young women are referred to the Multiagency Supporting Women in Antenatal Services (SWANS) Kirklees, and the MAPLAG meeting in Calderdale.
- Promoted National Contextual Safeguarding Awareness days.
- Developed 7-minute briefings on contextual safeguarding and county lines.
- Updated the intranet page to include resources on contextual safeguarding.
- Promoted the use of the Police Intelligence Portal (PIP)
- The team have an identified Contextual safeguarding/ CSE lead.

Priorities 2020-21

- To continue to raise awareness of the complex issues relating to contextual safeguarding and the use of multi-agency meetings to share intelligence around this.

FEMALE GENITAL MUTILATION

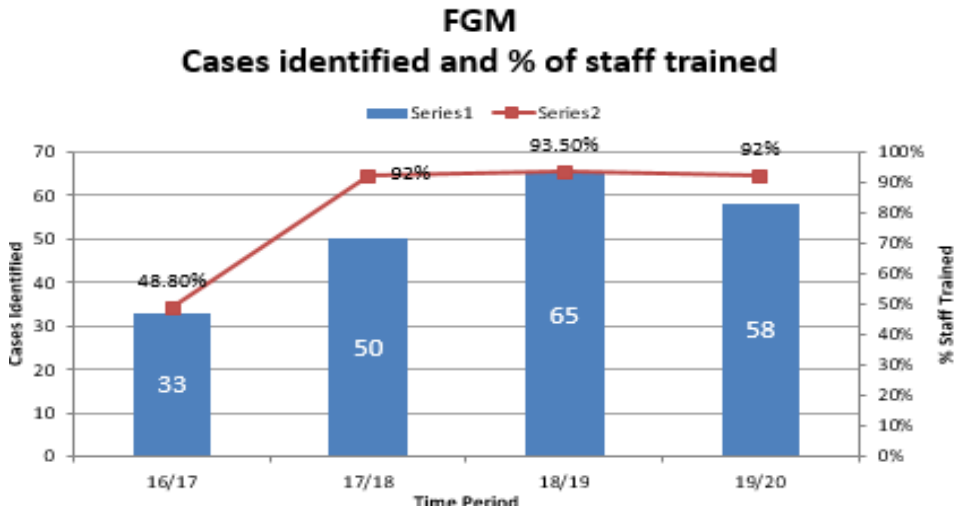
Female Genital Mutilation (FGM) encompasses 'all procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs, for non-therapeutic reasons.' FGM can have far reaching consequences for the physical, psychological and sexual health of those women and girls affected. It is a violation of their human rights, a form of child abuse and is illegal in the UK.

Since the introduction of the Female Genital Mutilation Act (2003; replacing the Prohibition of Female Circumcision Act (1985), FGM has been a criminal offence). The first successful prosecution took place in February 2019. With increasing international migration, the UK has become host to many women affected by FGM. Research suggest 279,500 women and girls in the UK have undergone FGM and a further 22,000 girls are at risk of the procedure. Since 2008 women with FGM have made up about 1.5% of all women delivering in England and Wales.

To ensure that CHFT meets its statutory requirements:

- The Trust has an identified FGM Lead
- An FGM Policy is in place which includes a flow chart to support staff with enquiring and assessing the levels of risk in relation to FGM.
- Statutory FGM reporting is carried out and the numbers of cases are also reported internally through the Safeguarding Committee Meeting.
- The Named Safeguarding Midwife attends FGM task and finish groups for both Calderdale and Kirklees.
- Routine enquiry is carried out in maternity services - if a woman is identified as a survivor of FGM during pregnancy, they are reviewed by the obstetric team and a data collection form is completed. Leaflets and information are provided to survivors of FGM and staff to raise awareness.
- Since Dec 2018 we have embedded the Female Genital Mutilation information sharing system (FGM-IS) at CHFT. Routine flagging of records is carried out if a mother is identified as being a survivor of FGM and any female new-born and female siblings (the flag is placed directly onto the NHS Spine). This ensures that the child is known as possible at risk of FGM wherever the child moves within the UK.
- CHFT have also flagged the known babies at potential risk on Cerner to ensure that a full risk assessment can be completed if presents with any concerns.

Date	Number of FGM Survivors presented at CHFT
2015/16	15
2016/17	33
2017/18	51
2018/19	65
2019/20	59



**this data shows a consistently high compliance which has resulted in continued reporting of cases of FGM*

Key Achievements

- Mandatory reporting of all cases of FGM is embedded within CHFT; reported quarterly to NHSE and the safeguarding operational group and committee meeting.
- The Safeguarding Team under 18 safeguarding risk assessment proforma includes FGM. This has now been adapted for use in the Gynaecology assessment unit and is to be embedded into practice throughout maternity services**.**
- Staff working in FSS, ED, the Safeguarding Team and the Integrated Sexual health Service receive additional FGM training -compliance remains consistently above 90%.
- FGM is routinely asked within maternity services.

Priorities 2020-21

- Participate in an audit with Locala to ensure that information is shared to the HV/GP of babies that are at risk.
- Work closely with the local authority to compare details of children that have been referred following birth to ensure that the process has been followed correctly.
- Work with both local authority in developing strategy meetings around the risk posed to the baby following confirmation of the mother been survivor of FGM
- Include the DOH risk assessment tool in Athena maternity records.
- Benchmark with other trusts and review their policies and procedures.
- Review FGM Policy.

DOMESTIC ABUSE

Domestic abuse is any incident or pattern of incidents of controlling behaviour, coercive behaviour or threatening behaviour, violence or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial and emotional abuse. It also includes 'honour'-based violence and forced marriage.

To ensure the Trust has robust arrangements there is

- A Named Lead for Domestic Abuse (DA). The role also supports Occupational Health and managers of staff who are victims/perpetrators of DA e.g. safety management plans. The role leads on policy and procedures and represents the Trust at strategic and operational multi-agency meetings specific to DA.
- CHFT hosts the Calderdale Commissioned Domestic Abuse (DA) Specialist Advisor which is in Calderdale's Domestic Abuse Hub. The Specialist Advisor for DA supports the DA Hub operationally on behalf of health services in Calderdale.
- Pennine Domestic Abuse Partnership provide a domestic abuse support worker to work into HRI to support staff to identify and refer patients experiencing domestic abuse to the right support, including completion of risk assessments. There has been a change in the role from September 2019 which does not include training support and regular attendance to the ED.
- A Domestic Abuse Policy which includes procedures for supporting staff members who are experiencing domestic abuse and what services are available. This policy provides an overview regarding alleged perpetrators and signposts to Managing Allegations policy if HR are required to be involved.

Referrals Made into the DA Hub (Calderdale) and the DRAMM (Kirklees) 2019-20

Month 2019/20	April	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	March	Total
Kirklees	7	7	5	7	6	4	5	2	2	3	6	0	54
Calderdale	10	9	8	8	5	9	8	4	4	5	1	1	72
Overall	17	16	13	15	11	13	13	6	6	8	7	1	126

- *This shows a significant reduction in the referrals at the end of Q4 reflective of the Covid- 19 pandemic in the reduction in attendances to both HRI and CRH.*
- *There is an overall decline at both sites during the winter period compared to summer months. There was an expectation this would increase in 2019 with the introduction of the new advanced practitioner role in Calderdale. This post is fulfilled by a DA support worker from Staying Safe; the locally commissioned service. Staying safe replicating the role of a Hospital IDVA role and funded regionally until December 2020.*

CHFT Domestic Abuse Health Service has continued during Covid-19 with virtual meetings. The DA hub is now hearing up to 160 cases a month and the demand on the service (including advice calls) continues to increase.

Number of CHFT referrals	2016/7	2017/8	2018/19	2019/20
Kirklees	37	61	64	54
Calderdale	60	59	81	72
Total	**97**	**120**	**145**	**126**

- *There has been a reduction in 2019-20 of 19 in total from 2018-19.*

Ongoing risks/challenges

It has been publicised and discussed nationally around the impact of COVID 19 lockdown may have in relation to increased and unseen domestic abuse.

The New Domestic Abuse Bill

The New Domestic Abuse Bill has identified that DA costs the country £66 billion and the cost implication of DA for health alone is £2.3 billion.

Whilst this is not yet in force, the legislation has identified some anticipated changes:

- the definition of DA to include economic abuse and controlling and manipulative non-physical abuse. It will identify a domestic abuse commissioner to drive the domestic abuse agenda forward. The other benefits of the legislation are prohibition of cross examination of victims by their abusers at family court and other protection orders that are currently being used now (DVPO/N's). The government is making 120 commitments which are non-legislative measures which includes:
- £8 million of Home Office funding to support children affected by domestic abuse · a new crisis support system for those with no recourse to public funds.
- additional funding and capacity building for services for disabled, elderly and LGTB victims · updated support, training and guidance on economic abuse.
- new and additional training for job centre work coaches, police, social workers and probation staff to help them recognise and effectively tackle abuse
- improved support for victims in the family court
- additional £500,000 funding for provisions for male victims

Key Achievements

- Clare's Law which is also known as the Domestic Abuse Disclosure Scheme was launched on the 24th January 2019 and seen an increase in referrals for both Kirklees and Calderdale CHFT supported in promoting this campaign.

Response to Covid-19:

- Disseminated a 7-minute PowerPoint presentation Trust wide including key messages, telephone consultations and risk management.
- Implemented a dedicated Covid-19 page where any relevant service change due to the pandemic or new guidance are continually updated.
- A briefing paper for all matters relevant to safeguarding was cascaded Trust wide in April which has information relating to DA, a hyperlink to the DA 7-minute briefing and directs staff to the dedicated intranet page.
- Not promoted the National Domestics Abuse campaign as advised by Calderdale and Kirklees Domestic Abuse Boards due to continued queries around how risks are managed and lack of referrals to local services for ongoing specialist support.
- Changes to the Sexual Assault Referral Centre (SARC) services updated on the Covid Safeguarding Intranet Page.
- The CHFT Domestic Abuse Health service continued to operate and manage advice calls from professionals. They continue to represent all health agencies at Calderdale's daily MARAC meeting.
- The Safeguarding team continue to receive and refer MARAC referrals from ED's at both sites and refer into the relevant meetings.
- Continued to refer to specialist support services for our patients where consent is obtained.
- Continued engagement with operational and strategic meetings specifically around how services are adapting to the social distancing guidance whilst risk managing families most at risk.

Priorities 2020-21

- Continue to work with all divisions ensuring that safeguarding adults and children and domestic abuse is part of all considerations when managing the reintroduction of services following Covid-19.
- Review the recommendations arising from the Domestic Abuse Bill and implement once this is in effect. This will include training and updates for staff, reviewing policies and procedures that may impact on practice.
- To review and re-implement the hospital domestic abuse support worker role that can support frontline staff at both hospital sites.
- Review the Domestic Abuse Policy.

CHILDREN LOOKED AFTER TEAM CALDERDALE

Our Children Looked After Health team work in partnership with Calderdale Metropolitan Borough Council (CMBC) to ensure that the health needs of children who are looked after (CLA) and young people in Calderdale are met. The health team provides advice and support to health and social care practitioners in order to improve health outcomes. A Looked after Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

The Designated Doctor for Children Looked After is part of this team and completes all the initial health assessments for all Calderdale CLA placed in Calderdale.

The service is closely monitored by both the Safeguarding Committee and partners of CMBC and CCG.

Key Achievements

- Procured additional Health passports for young people leaving care. This was done in consultation with Calderdale Care Leavers.
- Consolidated the 0-18 caseload so all CLA specialist nurses are experts at Review health assessments for all children /young people age 0-18.
- Worked with our young adult care leavers who wish to continue to receive support up to the age of 25 with their consent. This includes leaving the CLA flag in place on their EPR record which is removed at 25 or if they choose not to engage at 18.
- Promoted corporately a leaflet for both professionals/children/young people on differing aspects of what the service is that we deliver.
- The CLA team has continued to mature and develop, and bespoke training has been received within the team.
- The Public facing notice boards are regularly updated to share current information and services available.
- Continued to work in partnership with other agencies attending the CSE operational meeting and harmful sexual behaviour meeting sharing information and being part of the multi-agency discussion.
- At the start of COVID lockdown every 18-25-year-old care leaver was sent a letter out by the team offering support and advice and ways to contact the team including up to date public health advice around dentists, hand washing etc.

Priorities 2020-21

- Post Covid -19 recovery including review of team effectiveness during the Pandemic and post Covid surge in children being made subject to care orders
- Building and consolidating on the second full year service.
- CLA further support and engagement with the HAIG audit programme.
- Explore the use of continued virtual assessments with the national team.
- Collecting data for health needs analysis themes and key performance indicators.
- Continue to develop support links for care leavers over the age of 18.
- Engage in Yorkshire and Humber LAC working Group.
- Engage and support the process for delivering LAC and at ICS level and within Integrated care models.

CHILDREN LOOKED AFTER TEAM KIRKLEES

The Looked After Children's (LAC) Health Team covers the whole of Kirklees not just the Huddersfield area. The Designated Doctor and Medical Advisers are based at Huddersfield Royal Infirmary and employed by CHFT, and the Designated Nurse and Specialist LAC nurses are employed by Locala but based within Children's Social Care at Civic Centre 1 with access to Social Care's IT system.

Looked After Children Health services in Kirklees perform well in meeting the required timescales set out in statutory guidance.

Current Position and Statistical Information

- The numbers of children becoming 'looked after' has shown a steady incline.
- There is an increase of 81 Initial Health assessments IHA's) compared to the previous year.
- 95.5% were completed in statutory timescales.
- 3 IHA's completed on behalf of Kirklees.
- 5 IHA's completed by Kirklees, on behalf of other Local Authorities (LA)

TRAINING AND SUPERVISION

The provision and delivery of safeguarding training for both children and adults remains a key priority. It is a mandatory requirement for all staff to undergo this training to attain competencies appropriate to their role. As such our training is delivered in line with the intercollegiate documents for both safeguarding children and adults.

Risks Identified

- A review of the level 1 safeguarding training package this year it was identified that this did not meet the intercollegiate document (2019) requirements or that Prevent Basic awareness was in this. This was escalated via Designated Professionals to NHSE and the Regional Prevent Lead.
    - All staff have now been assigned Prevent Wrap training.
    - Due to COVID 19, the level 3 safeguarding training packages are available for staff to complete via the intranet.
    - The team has ensured sufficient level 3 training places provided and additional sessions facilitated by the team for non-compliant staff and those likely to come out of compliance in 2019-20; but despite non- attenders at training sessions; the predicted target of 90% compliance of all levels was not met by March 2020.

	31.03.2019					31.03.2020				
	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %
	5730	21559	19648	1911	91.14%	5842	21938	20155	1783	91.87%
Competence Name	Assignment Count	Required	Achieved	Outstanding	Compliance %	Assignment Count	Required	Achieved	Outstanding	Compliance %
NHS|MAND|Mental Capacity Act - 3 Years|	405	405	400	5	98.77%	285	285	277	8	97.19%
NHS|MAND|Mental Capacity Act Level 2 - 3 Years|	3117	3117	2684	433	86.11%	3254	3254	2960	294	90.96%
372|LOCAL|Mental Capacity Act Level 3 - 3 Years|	735	735	651	84	88.57%	639	639	582	57	91.08%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	1609	1609	1553	56	96.52%	1663	1663	1631	32	98.08%
NHS|MAND|Safeguarding Adults Level 2 - 3 Years|	3503	3503	3361	142	95.95%	3602	3602	3315	287	92.03%
NHS|MAND|Safeguarding Adults Level 3 - 3 Years|	616	616	554	62	89.94%	557	557	473	84	84.92%
372|LOCAL|Female Genital Mutilation|	486	486	453	33	93.21%	488	488	456	32	93.44%
NHS|MAND|Prevent WRAP - No Renewal|	4599	4599	4282	317	93.11%	4953	4953	4669	284	94.27%
NHS|CSTF|Safeguarding Children - Level 1 - 3 Years|	1609	1609	1557	52	96.77%	1660	1660	1625	35	97.89%
NHS|MAND|Safeguarding Children Level 2 - 3 Years|	3655	3655	3478	177	95.16%	3616	3616	3325	291	91.95%
NHS|MAND|Safeguarding Children Level 3 - 3 Years|	550	550	503	47	91.45%	545	545	437	108	80.18%
372|LOCAL|Mental Health Act Receipt and Scrutiny Training|	61	61	19	42	31.15%	81	81	47	34	58.02%
372|LOCAL|Safeguarding Supervision|	614	614	153	461	24.92%	595	595	358	237	60.17%
Grand Total	**5730**	**21559**	**19648**	**1911**	**91.14%**	**5842**	**21938**	**20155**	**1783**	**91.87%**

Key Achievements

- This year compliance has improved in all levels.
- Level 2 e-Learning has been reviewed in line with the Intercollegiate document and awaiting launch with updated level 3 packages.
- The Safeguarding Supervision Policy for Children was re-reviewed and approved at the Safeguarding Committee.
- Supervision has increased by 35%.

Priorities 2020-21

- To review delivery of level 3 in September 2020 post Covid and facilitation of face to face sessions with due consideration to social distancing and Trust guidance.
- To continue to ensure Divisions are kept updated regarding compliance reports.
- To update the Supervision Policy to include Adults.
- To develop local supervision models for staff who work primarily with adults.

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SAFEGUARDING REVIEWS

The purposes of safeguarding reviews is to enable Local Safeguarding Boards/Safeguarding Partnerships and Community Partnerships to fulfil their obligations under the Children Act (2004), The Care Act (2014) and the Domestic Violence and Victims At (2004).There has been a total of 15 requests this year for information, and 27 records reviewed. This is an increase of 9 requests from last year.

Cases for 2019/20

- **Serious Case Reviews (now Child Serious Practice Reviews)**
  - There has been 4 new Serious Case Review's commissioned by the Local Safeguarding Children Partnerships.
  - The Trust has been involved in 2 cases from previous years at varying stages of progress.
- **Thematic Reviews (Children)**
  - There are 3 ongoing thematic reviews led by the Childrens Partnerships.

- **Serious Adult Reviews**
  - There has been 2 new Serious Adult Review commissioned by the Local Safeguarding Adult Boards, and a learning lessons review.
  - The Trust has been involved in 1 case from previous years where action plans have been re-visited by the Safeguarding Board.

- **Domestic Homicide Reviews**
  - There have been no new DHR's commissioned locally.
  - The Trust is currently involved in 2 DHRs from previous years

Key achievements

- Fulfilled partnership requests for information and contributed as authors and panel members to Childrens Practice Reviews, Serious Adults reviews and Domestic Homicide Reviews.
- Met the Rapid Review timescale process of 5 days in sharing information.
- Continued to monitor reviews and action plans though the safeguarding operational group and safeguarding committee meeting**.**

Priorities 2020-21

•To strengthen lessons learned arrangements for external reviews into revised internal lessons learned processes.

SAFEGUARDING AUDITS

The safeguarding operational group is responsible for establishing a programme of planned audit activity. This year the meeting has received several audits which, whilst meeting the requirement for assurance, has potential to bring about tangible clinical benefits, reflecting national and local priorities and taking into consideration 'top down' projects critical to delivering Divisional business / targets along with 'bottom up' projects proposed by clinical staff / teams. The group is responsible for monitoring progress and ensuring improvements are being implemented and sustained in response to project recommendations.

Section 11 of the Children Act 2004 places a statutory duty on organisations and individuals to ensure their functions are discharged having regard to the need to safeguard and promote the welfare of children.

Our local audit programme for 2019-20 has included:

- An audit of patients that left the ED
- Compliance of the Burns Bruise and Scalds Protocol
- The Completion of EPR Safeguarding mandatory questions
- All safeguarding cases regarding multi-agency practice is being adhered to
- Social care plans for birth by 36 weeks
- Positive enquiry from routine enquiry
- The timeliness of DASH risk assessment completions
- DoLS prevalence and IMCA services audit
- Quality assurance of child protection medicals

Outcomes

Actions were implemented and continue to be monitored on a yearly basis.

Key Achievements

Completed two section 11 audits requests for Calderdale and Kirklees Safeguarding Board/ Partnerships.

All audits are now on the Trust Audit Programme for 2020-21.

Priorities 2020-21

- To continue to progress actions with Divisions and work with the Clinical Commissioning Group to complete these.
- To continue to respond to section 11 requests for updates.
- Where themes / trends occur to ensure audit is embedded into practice.
- Complete the Section 11 for Calderdale Safeguarding Children's Partnership and Adults Board for the end of January 2021

COMPLAINTS/SERIOUS INCIDENTS AND LEGAL SERVICES

Regular meetings have taken place with the Governance and Risk team and Head of Safeguarding to ensure oversight of cases / incidents / complaints / claims / inquests with safeguarding aspect.

For serious incident investigations in 2019-20 that had a safeguarding aspect a safeguarding expert has been asked to review the report at draft stage prior to approval, for more complex cases they have contributed throughout the investigation as an expert investigator working with the lead investigator. The senior risk manager has reported to the Safeguarding Operational Group and Safeguarding Committee on serious incidents during the year.

Key achievements

- There have been several very complex cases jointly worked with the legal team and safeguarding team that has improved outcomes for our patients.
- Improved recognition of Complaints that require referral into safeguarding procedures though joint working.
- Shared data monthly to review.

Priorities 2020-21

- Work with the Legal Services Team to formalise process for Court of Protection cases.
- Work with Legal Services for oversight of the process for Court Statement requests.
- We will continue to build on these links during 2020-2021.
- The terms of reference for Serious Incident Investigations will require safeguarding expertise as part of the investigation where there is a safeguarding element to the case.
- To align internal governance arrangements where SCR/DHR/SAR are recorded in line with the SI arrangements in the trust.

SAFEGUARDING BOARDS AND CHANGES

In April 2019, the Calderdale Safeguarding Children Board (CSCB) and the Kirklees Safeguarding Childrens Board became the Calderdale / Kirklees Safeguarding Children Partnership (CSCP/ KSCP), following the Department for Education's Working Together to Safeguard Children report from July 2018 which introduced Safeguarding Children Partnerships to replace local Safeguarding Children Boards across the country. These new legal requirements make local police, councils and health services jointly responsible for keeping children safe, and accountable for how well agencies work together. It has also increased opportunities to work more closely with the other Safeguarding Partnerships across West Yorkshire to improve learning, share resources, increase understanding of the effectiveness of safeguarding activity and ultimately to improve services for children and families.

CHFT contribute to the Child Death Overview Panel (CDOP) arrangements across Kirklees and Calderdale. The safeguarding team supports these arrangements and notifies the partnership of any child deaths. The Head of Midwifery attends the CDOP panel.

CHFT Safeguarding Team continues to be an active partner and supports the multi-agency partnership working with the Safeguarding Children Partnership arrangements and the Adult Safeguarding Boards and their subgroups for both Kirklees and Calderdale. This involves true partnership and shared goals and development throughout the year.

Key achievements

- Attended Safeguarding Adults Boards and Childrens Partnership meetings and associated subgroups
- Attended Local partnership Health Meetings to ensure the Governance and accountability for the Childrens Partnership arrangements are robust, and the Executive lead in the CCG and safeguarding partnership meets their statutory responsibility.

CONCLUSION

The Safeguarding Annual report demonstrates that safeguarding children, young people, families and adults at risk remains a key Trust priority, demonstrating that CHFT is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework and from a national perspective.

The Trust has responded to these changes and to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant progress and achievements have been made in all the key safeguarding agenda's detailed in this report, the team have prioritised and identified the key strategic developments required for 2020-21. These may change in line with other Trust priorities, emerging challenges nationally and the wider partnership priorities including national directives.

Our key underpinning message is that Safeguarding is everybody's responsibility regardless of their role within the Trust.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Our Safeguarding Strategy for 2020-2022

Its Everyone's Responsibility

Calderdale and Huddersfield NHS Foundation Trust (CHFT) will use this strategy over the next 2 years to drive forward and embed the Safeguarding agenda across the organisation. This strategy should be used in conjunction with CHFT Safeguarding Children & Adults policies (and other relevant trust policies)

Introduction

Calderdale and Huddersfield Foundation Trust (CHFT) serve Calderdale; population 208,400 and Kirklees 434,300, We employ around 6,000 staff who deliver compassionate care from our two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary as well as in community sites, health centres and in patients' homes.

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

We provide community health services, including sexual health services in Calderdale from Calderdale Royal and local health centres. These include Todmorden Health Centre and Broad Street Plaza. We also provide acute inpatient and community maternity care across Calderdale and Kirklees.

In 2018/19 we cared for more than 119,000 men, women and children as inpatients. There were also more than 440,000 outpatient attendances; 150,000 accident and emergency attendances and 5,000 babies delivered. There were some 260,000 adult services contacts by our community teams as well as 283,000 contacts with our therapy services.

Safeguarding – The Context

Safeguarding is firmly embedded within the core duties of all organisations across the health economy. The context of safeguarding continues to change in line with societal risks both locally and nationally, the learning from safeguarding reviews and changes in legislation. It is the responsibility of every NHS funded organisation, and each individual healthcare professional working in the NHS, to ensure that the principles and duties of safeguarding children and adults are holistically, consistently and conscientiously applied to ensure that the well-being of those children and adults is at the heart of what we do.

Every NHS funded organisation needs to ensure that enough capacity is in place for them to fulfill their statutory duties; they should regularly review their arrangements to assure themselves that they are working effectively. Organisations need to co-operate and work together to seek common solutions to the changing context of safeguarding, to improve outcomes for families and to support the delivery of the NHS Long Term Plan.

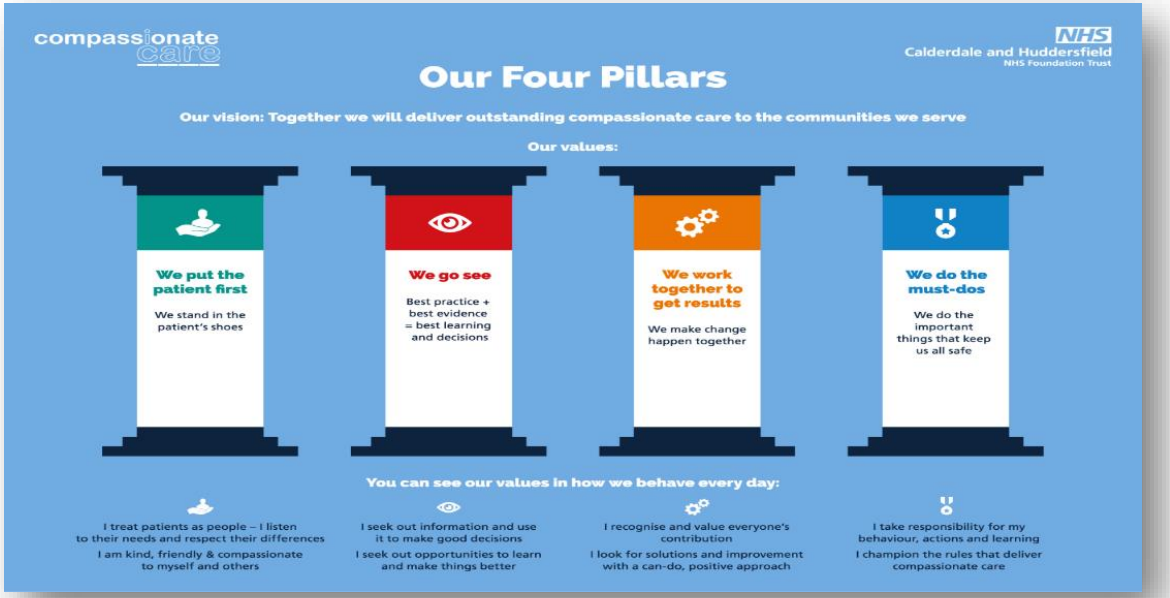
CHFT Safeguarding Pledge

CHFT is committed to protecting the safety and welfare of children and adults and this is at the heart of everything we do. It is the individual's right to be kept safe from harm, abuse or neglect. Everyone at CHFT has a responsibility to safeguard families and communities. Together we will deliver outstanding compassionate care to the communities we serve

CHFT is fully committed to Safeguarding everyone regardless of gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status, civil partnership. CHFT has robust safeguarding policies in place which follow both local and national legislation and guidance. These place a duty upon every employee who has contact with children, adults and families in their everyday work to safeguard and promote their welfare. The Trust has nominated safeguarding leads who advise and support professionals when they raise concerns about a child or adult's welfare.

Safeguarding is characterised by shared decision making and joint working. Whilst parents and carers have primary responsibility for those in their care, Statutory responsibility to safeguard children & adults lays with social care & police, however this duty can only be fulfilled when there is full cooperation between all agencies involved with the family.

The Trust will follow the vision and values outlined in 'Our Four Pillars'. We will act in partnership with other key agencies to take appropriate action when abuse or neglect is suspected. This will include sharing information and referring to the statutory agencies; police and social care, when required.



Our Purpose

CHFT aims to ensure that:

- safeguarding is everyday business across the organisation, evidenced in all areas of the Trust's activities and business.

- staff are empowered to speak up and act when they see or suspect safeguarding issues by ensuring that they receive appropriate level training based on national and local standards
- patients are protected by ensuring that Organisational Policies and Processes are streamlined to facilitate staff to do the “right thing”
- we work in partnership with other agency colleagues to facilitate co-operation in a transparent and productive way to progress safeguarding
- outcomes for children ensure they get the best start in life
- we support adults at risk through more personalised care.

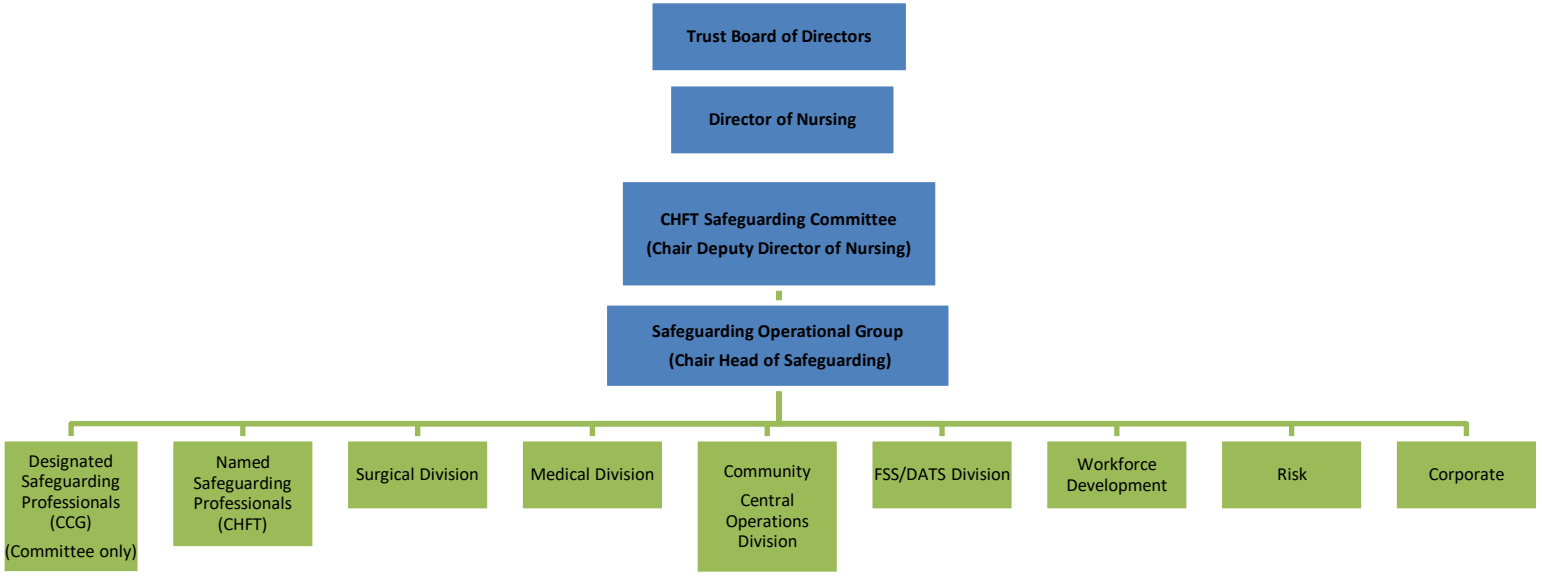
Our Safeguarding Service

The CHFT Safeguarding Team is a team of health professionals who can support and advise all members of CHFT staff in discharging their safeguarding duties. We also ensure:

Safeguarding Governance

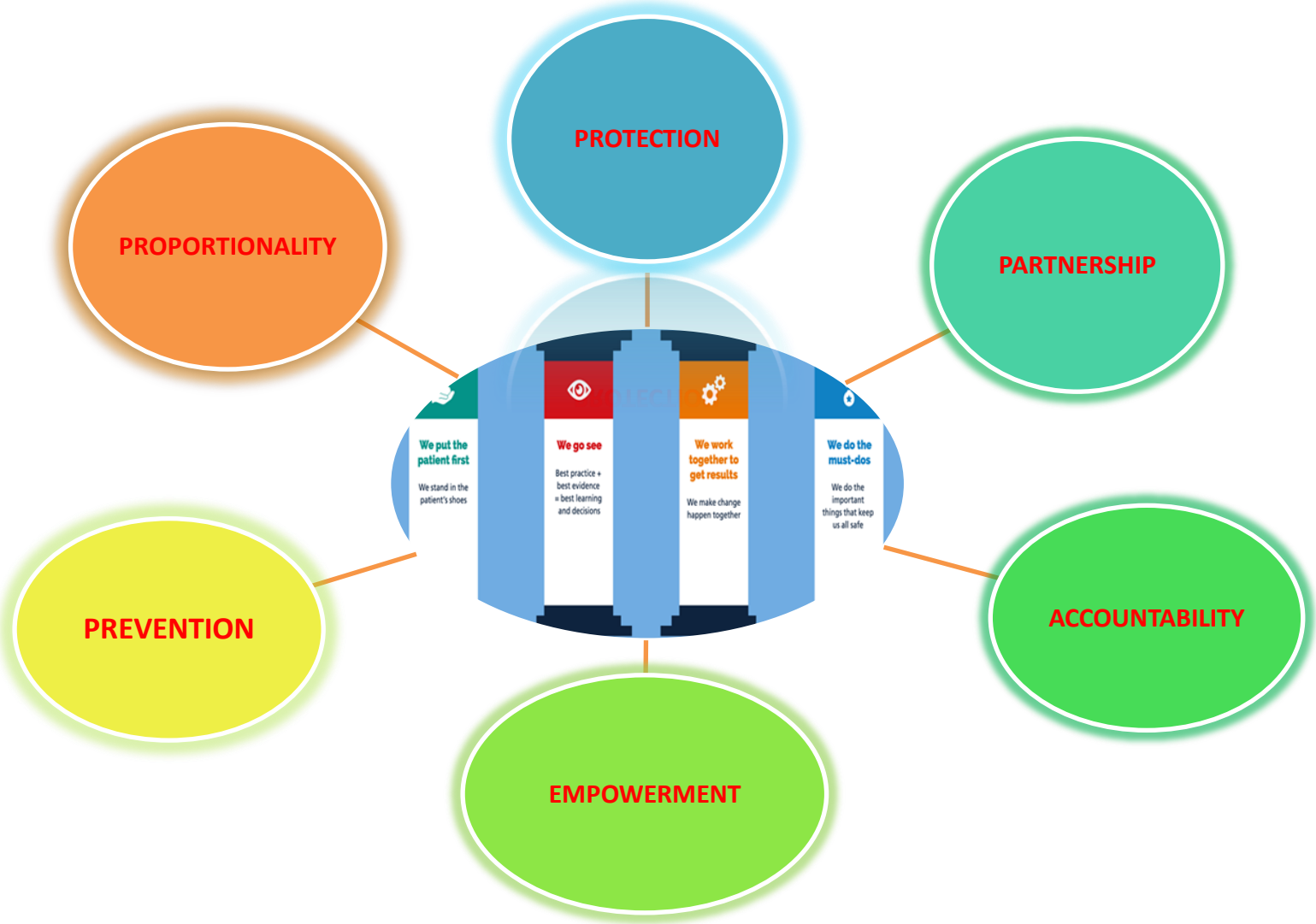
The Head of Safeguarding completes an annual report of progress and achievements made regarding Safeguarding to the Trust Board of Directors. There are both operational and strategic committee meetings that take place monthly which provides an opportunity to share good practice and escalate any issues to senior leaders. The Operational group allows an arena for the Safeguarding team to update divisions on ongoing work, changes in safeguarding agendas, audit outcomes and good practice. This meeting also provides an opportunity for divisions to share concerns, good practice and all issues requiring

escalation are then shared with the bi-monthly Safeguarding committee meeting. The Safeguarding Committee meets bi-monthly where the structure for these are as detailed below:



Plan

We continue to embed safeguarding throughout CHFT in line with the six safeguarding principles detailed below:



TARGETED AREA OF WORK	ACTION	SERVICE OUTCOME	ASSURANCE/EVIDENCE
PROTECTION			

1.Impact of Covid-19 on safeguarding families 2.Safeguarding implication of mental health needs 3.Ending Violence against Women and Children (Inc. FGM) 4.Contextual safeguarding (CSE, CCE, HSB and MDS) 5.Preventing radicalisation 6.Domestic Abuse Bill	Review home Office Prevent Training Review impact of Covid 19 on emotional well-being of pregnant women/ share resources. Paediatric Liaison process review Build U18 proforma into EPR Embed safeguarding in stabilisation and reset of CHFT services Continue to raise awareness on Contextual safeguarding issues Review CLA team effectiveness post Covid 19 Continue to develop support for Care leavers	Consistently update all staff on changing safeguarding agendas, local and national legislation/guidance to support safe practice. CHFT supports all staff to become competent & skilled in understanding and fulfilling their safeguarding responsibilities.	Virtual Noticeboard, 7-minute briefings and Learning bulletins disseminated through PSQB Continuously updated mandatory training packages (adults& children) Progress reports to safeguarding operational group with escalation to safeguarding committee/ annual report
EMPOWERMENT			
1.Mental Capacity Act - Implementation of Liberty Protection Safeguards 2.Childs Voice 3.Making Safeguarding Personal 4.Transition and reasonable adjustments 5.SEND Reforms	Continue to embed MSP Work alongside the Treat me well Campaign Implement MCA Template into EPR/ Athena Continue to embed MCA practice Implement new LPS collaboratively and internally Review LPS/MCA codes of practice Identify SMART outcomes for Pregnant women with MH issues Embed the Safeguarding Tool incorporating PNMH guidance Respond to Section 11 and embed learning	CHFT supports all staff to feel confident in seeking the voice of their patients & families, ensuring that this directly informs what happens in relation to safeguarding practice Empowering staff to have confidence and skills to effectively contribute to MDT decision making around the family	Section 11 (adults and children) Audit (multi-agency) Debrief & Safeguarding supervision (team and 1:1) CETRS documents Progress reports to safeguarding operational group with escalation to safeguarding committee/ annual report
PREVENTION			
1.Quality improvement work e.g. falls, safe discharge, pressure ulcers, managing complex needs 2.Neglect and Self-Neglect	Improve and monitor falls reporting through safeguarding procedures Production of training film by Treat me well Group	CHFT ensures all staff, patients & families receive clear and accurate information about what constitutes abuse, how to recognise the signs and what further actions should be taken.	Progress reports to safeguarding operational group with escalation to safeguarding committee Safeguarding Annual report

3.Information sharing 4.Covid Safeguarding Surge Plan	CLA team to continue to collect and collate data and KPI's.	CHFT staff are clear on early intervention and recognition of abuse and report through accordingly. Continuous analysis of data from incidents reported and sharing key messages (e.g. DATIX, SI and case reviews)	Covid Stabilisation & reset workstreams Covid Safeguarding workstream
PROPORTIONALITY			
1.Escalation process 2.Working Together to Get Results	Review Missing Policy Review Was not Brought Policy for Adults Explore building a questionnaire into Datix regarding pressure ulcers Explore use of technology completing continued virtual assessments (CLA team)	CHFT will ensure that all staff will work for the best interest of the child/adult/family at risk. CHFT staff will have a clear understanding their responsibilities in how to escalate concerns and refer appropriately to safeguarding procedures.	Operational group with escalation to safeguarding committee/ annual report
PARTNERSHIP			
1.Safeguarding reviews/inspections 2.Safeguarding week 3.Multi agency Partnership working 4.Board/partnership Sub-groups	Contribute and promote safeguarding week Monitor progress/embedding of pressure ulcers though pressure ulcer collaborative Update Joint MH protocol/ SLA Continue to share information with partners that informs single and multi-agency practice Complete FGM audit with Locala Work collaboratively with LA to share information relating to FGM cases CLA engagement with Yorkshire and Humber and delivery of CLA at ICS level.	CHFT promotes a learning culture to ensure continuous safeguarding practice improvement. Ensuring good partnership working and effective communication between CHFT and the safeguarding board/partnerships CHFT staff are supported to have the confidence and ability to contribute to the multi-agency progress where appropriate CHFT staff will know how to access training and learning items from national and local DHR/SAR/CSPRs which will be applicable to practice Safeguarding team members continue to chair and lead on multi-agency meetings e.g. DA Hub, SWANNS	Engagement in multi-agency audit, HAIG, HAG, subgroups and evidenced through reports to safeguarding operational group with escalation to safeguarding committee Safeguarding Board/Partnerships annual report including CDOP and MBRACE report Participation in local and national networks to benchmark practice JTAI, Section 11 and CQC reports
ACCOUNTABILITY			
1.Safeguarding champions 2.Safeguarding documentation 3.Safeguarding Policies and procedures	Increase number of Prevent Champions/ develop safeguarding Champions Develop Adult Supervision Policy/ Strategy Revise PU policy	CHFT has an organisational culture where staff are aware of and supported to fulfil their safeguarding responsibilities All policies and procedures will be reflective of national changes and locally amended to reflect	Progress reports to safeguarding operational group with escalation to safeguarding committee Training and supervision compliance and targets reviewed at PSQB, (DASHBOARD) including key messages

4.Safeguarding audit 5.Safeguarding Supervision and training programme	Audit PU with a safeguarding concern Standardise the RAC tool Review L2/L3 training packages Ensure Trust Board oversight of progression of LPS Propose Business Case to implement system change Continue to promote R&S training Continue to embed Supervision Complete MH Policy Review DA support role Review recommendations of DA Bill once implemented CLA audit engagement Strengthen internal learning for external reviews Review TOR for SI where safeguarding expertise is required	the current safeguarding circumstance. Divisions are fully aware and responsible for supporting their staff for fulfilling their safeguarding responsibilities e.g. training and supervision compliance, disseminating learning from incidents internally and externally to CHFT.	Trust safeguarding audit programme Safeguarding Annual report

KEY

CCE – Child Criminal Exploitation CDOP
CSE – Child Sexual Exploitation
DA HUB – Domestic Abuse
HAIG – Health Assurance and Information Group
JTAI – Joint Targeted Area inspection
MBRACE – Mother and babies reducing risk audits and confidential enquiries
PSQB – Patient Safety and Quality Board
SI – serious incident
CDOP- Child Death Overview Panel
CETR – Child Education Treatment Reviews
DHR – Domestic Homicide Review
HAG – Health Alliance Group
LMS – Local Maternity Systems
MDS – Modern Day Slavery
SAR – Safeguarding Adults Review
SWANS – Supporting Women Antenatal Services
CQC – Care Quality Commission
CSPR – Child Serious Practice Reviews
FGM – Female Genital Mutilation
HSB – Harmful Sexual Behaviour
MAPLAG – Multi-Agency Pregnancy Liaison Advisory Group
MDT – Multi-Disciplinary Team
SEND – Special Educational Needs & Disability

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Planning transition to adulthood for care leavers (2015) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/397649/CA1989_Transitions_guidance.pdf
WYNY&YPP
Children's WYPP

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Department of Health (2019) Statutory framework DAWN
Department of Health (2009) *Responding to domestic abuse: a handbook for health professionals* National Institute for Health and Clinical Excellence (2009) *When to suspect child maltreatment.* NICE Clinical Guideline
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NHS England and NHS Improvement: Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework – August 2019

NHS Long Term Plan

NHS
Calderdale and Huddersfield
NHS Foundation Trust

SAFEGUARDING ANNUAL REPORT HIGHLIGHTS 2019/20

NHS
Calderdale and Huddersfield
NHS Foundation Trust

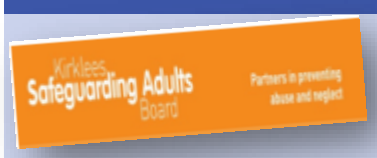
Highlights from the Annual Safeguarding Report 2019-2020

PREVENT

•CHFT fulfilled all requirements for the **PREVENT duty** as part of the NHS contract, with quarterly updates to NHS England.

•Training has remained consistently **above 90%** - meeting the Trust target of 90% and NHSE target of 85%

ADULT SAFEGUARDING



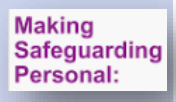
• Overall there has been a **reduction** of safeguarding referrals and concerns made **against** CHFT

•The continued **increase** in the number of referrals made by providing assurance of robust reporting arrangements and staff awareness of procedures.

• Flow charts developed for staff to follow and 7-minute briefings

2020/21:

• Continue to embed **'Making Safeguarding Personal'**

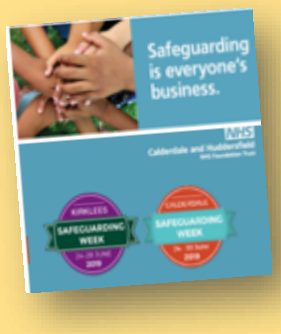


"Safeguarding in practice"

When a patient attended the ED earlier this year at HRI intoxicated and with indicators of being trafficked, alarm bells started to ring for a member of our staff. A referral was made to Adult social care. We flagged her electronic patient record with 'at risk of Human trafficking' with detailed instructions to contact the Police for advice if she re-attends regardless of consent due to the risk and concerns. A password was set up and a referral made to the local Multi-Agency Risk Assessment Conference (MARAC). Staff worked closely with the CHFT Hospital IDVA where she was sign posted to Palm Cove. Further attendances to ED linked in well also with the hospital social work team and the police. What arose from this case was that she had been trafficked from Hungary and sexually exploited. The aim in this case was to re-patriate her back to Hungary

SAFEGUARDING WEEK (CHILDREN AND ADULTS) AND OTHER PROMINENT DAYS

•The CHFT Safeguarding team worked with local safeguarding partners to promote **safeguarding week,** disseminating key messages and events available



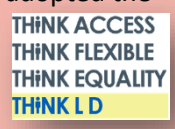
LEARNING DISABILITY

•CHFT were part of the pilot data collection for the National **NHS Improvement LD Standards** in 2019 and again in 2020

•CHFT signed up to take part in the first phase of Royal Mencap's **Treat me well campaign**

• CHFT took part in the first **NHSI Transition collaborative** which started in May 2019

• CHFT have adopted the **THINK LD Campaign**



PRESSURE ULCERS

•Developed a suite of tools for clinical pressure ulcer **prevention and management** - issued to all community nursing teams across the Trust

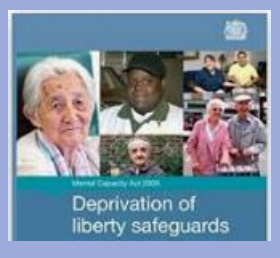
2020/21:

• Standardise **root cause analysis** tool including **48-hour rapid review** to support consistent approach across divisions

MENTAL CAPACITY AND DEPRIVATION OF LIBERTY SAFEGUARDS

Positive level of awareness, with an average of **87% of applications** made by the ward

• Only **33%** of referrals required some **minor amendments**; wards are now completing their **own authorisations**



MENTAL CAPACITY (AMMENDMENT) BILL

2020/21:

• Awaiting **MCA and DoLS Codes of Practice** - will have **major implications** for Hospital Trusts and Community Services

MENTAL HEALTH ACT

• Fulfilled **statutory duties** under the SLA which formalises the partnership arrangements between CHFT and SWYPFT

• Established a **Mental Health Operational Group** involving SWYPFT

SAFEGUARDING MENTAL HEALTH AND MIDWIFERY

• Developed a **joint ante natal clinic** involving the Perinatal Clinical Lead, Lead Obstetrician for Perinatal mental health and the PNMH Team Psychiatrist

2020 / 21:

• To review the impact that **Covid 19** Pandemic has had upon the **emotional wellbeing** of pregnant women and mental health services available to them. To disseminate any digital / virtual resources amongst maternity staff and service users

CHILDREN AND YOUNG PEOPLE

• 7-minute briefing and SOP developed a in relation to the **BBS (burns bruises and scalds) protocol**

• New Trust policies developed:
- the **'Care of a Child/ Young Person with Mental Health Needs'**
- in relation to missed appointments - **'Was Not Brought'**

Calderdale Safeguarding Children Board

Kirklees Safeguarding Children Board

CONTEXTUAL SAFEGUARDING

• 7-minute briefings been developed and shared on **contextual safeguarding and county lines**

• Worked collaboratively with partners to **share and receive information** in relation to wider community risks

FEMALE GENITAL MUTILATION

- Maintained a consistently **high compliance (over 90%)** with training which supports the **continued reporting of FGM cases**

- **Mandatory reporting** of all cases of FGM is embedded within CHFT - reported **quarterly to NHSE**

2020/21:

- CHFT are participating in an audit with Locala regarding **information sharing** to ensure that information is shared to the HV/GP of babies that are at risk

DOMESTIC ABUSE

- The risks associated with **clinicians not seeing patients** due to the impact of **'lockdown' during Covid-19** outbreak are being looked at through the stabilisation and reset work streams trust wide

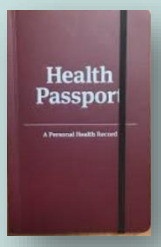
- CHFT Safeguarding team have responded to Covid-19 and Domestic Abuse **provided a briefing paper for staff**

- Shared a 7-minute PowerPoint presentation trust wide in April including key messages, services, telephone consultations and **risks relating to lockdown**

2020/21:

- Implement the recommendations arising from the **Domestic Abuse Bill.** This will include **training** updates for staff, reviewing **policies and procedures** that may impact on practice

CHILDREN LOOKED AFTER TEAM CALDERDALE



- Procured more **Health passports** - designed and printed locally, in consultation with **Calderdale Care Leavers**

- At the start of COVID lockdown **every 18-25-year-old care leaver was sent a letter** out by the team offering **support and advice** and ways to **contact** the team including up to date public health advice around dentists, hand washing etc

2020/21:

Monitor closely any post Covid surge in children being made **subject to care orders**

LOOKED AFTER CHILDREN TEAM KIRKLEES

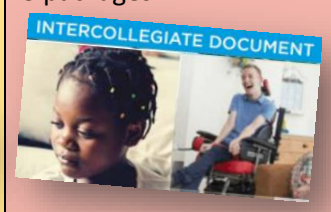
- Looked After Children Health services in Kirklees perform well in **meeting the required timescales** set out in statutory guidance

- An **increase of 81** initial Health Assessments compared to the previous year. **95.5%** were completed in statutory timescales

TRAINING

- This year compliance has **improved in all** safeguarding training levels

- Level 2 eLearning has been reviewed in line with the **Intercollegiate document** and awaiting launch with updated level 3 packages



SAFEGUARDING SUPERVISION

- Significant improvement in supervision compliance rate – **increased by 35%**

MULTI-AGENCY SAFEGUARDING REVIEWS

- The Safeguarding Team **have fulfilled partnership requests** for information and **contributed to several reviews** that have been published and are ongoing

SAFEGUARDING AUDITS

- Completed **two section 11 mandatory audits** - Calderdale and Kirklees
- Delivered a planned **programme of audit activity**

COMPLAINTS AND LEGAL SERVICES

- Worked jointly with the legal team on several very **complex cases** which have improved outcomes for our patients

SERIOUS INCIDENTS

- **A safeguarding expert** has reviewed the draft report of any **serious incident investigations with a safeguarding aspect;** for more **complex cases** they have contributed throughout the investigation as an **expert investigator** working with the lead investigator

INSPECTIONS

- The safeguarding team contributed to the **successful monitoring visit** of the Apprentice team -this was in readiness for a full inspection; **'Reasonable Progress'** was achieved across all 3 themes which includes how **'Prevent' and safeguarding training** are delivered to the apprentices by the safeguarding team

SAFEGUARDING BOARDS AND CHANGES

- CHFT continues to work with the **Safeguarding Children Partnership arrangements** and the Adults safeguarding Boards for both Kirklees and Calderdale. This involves true **partnership** and **shared goals** and **development** throughout the year
- CHFT contribute to the **Child Death Overview Panel** arrangements across Kirklees and Calderdale - supports the arrangements and notifies the partnership of any child deaths. The **Head of Midwifery** attends the CDOP panel

Icons made by Freepik from www.flaticon.com

4. Hospital Pharmacy Service Annual Report

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 3 September 2020
Meeting:	Board of Directors
Title:	Huddersfield Pharmacy Specials (HPS) Annual Report
Author:	Dr Burrinder Grewal, Managing Director, HPS
Sponsoring Director:	Gary Boothby, Executive Director of Finance
Previous Forums:	The HPS Annual Report has been reviewed by the members of the HPS Board outside of a formal Board meeting
Actions Requested: To note	
Purpose of the Report	
The report outlines the structure and activities of Huddersfield Pharmacy Specials (HPS) for the financial year 2019/20. The report is provided to full Trust Board for assurance.	
Key Points to Note	
HPS delivered its key objectives during 2019/20. The financial plan was delivered offering a contribution of £3.4m. Whilst key workforce objectives of appraisal, training and sickness rates were met, the staff survey once again proved disappointing. A co-produced action plan was developed and fully implemented based on the 20/18/19 survey. This was monitored at HPS Board meetings that took place every other month. HPS have maintained full regulatory compliance throughout 2019/20. Funding remains to be identified in order to deliver the previously approved Trust Board strategy.	
EQIA – Equality Impact Assessment	
The report provides an update for information only on the activities of HPS throughout 2019/20 and requires no decision which has an impact upon equality.	
Recommendation	
The Board is asked to note the contents of the attached report.	

Annual Report FY2020
Huddersfield Pharmacy Specials

1. Introduction

Huddersfield Pharmacy Specials (HPS), also referred to as the Pharmacy Manufacturing Unit (PMU), is a division of Calderdale & Huddersfield NHS Foundation Trust. HPS is a manufacturer of unlicensed sterile and non-sterile products known as Specials. Additionally, HPS provides a medicines over-labelling and re-packing service to hospitals and private providers, both contract manufacturing and research and development, and wholesaling of licenced medicines. Of particular note (and as previously announced), during FY20 HPS continued the commercialisation of clinical trial services provided to third party organisations. We present below key achievements and the division's operational and financial performance during the financial year FY20 (1st April 2019 to 31st March 2020).

2. Structure, Governance and Management

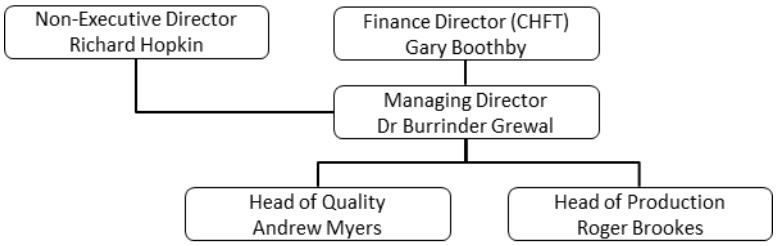
HPS trades from purpose built facilities (33,000 sq. ft. of space) located at Acre Mill (School Street West), Huddersfield. The unit operates under the authority and licences issued by The Medicines and Healthcare Products Regulatory Agency (MHRA), the UK medicines regulator. The licences the unit have which permit it to operate, manufacture and provide services are listed below; in February 2020 the unit was audited by the MHRA and successfully became licenced to manufacturer licenced (non-sterile) medicines for the first time (this was the culmination of some two years of prior work). Post period and in response to additional manufacturing requirements related to management of COVID19, HPS increased its capability to procure alcohols.

Table 1: HPS licences and certifications

Licence/Certificate	Licence/certificate no.	Issue Date	Expiry Date
Manufacturers "Specials" Licence	MS 19055 version 16	29 November 2001	Ongoing
Manufacturers/Importer's Licence (MIA)	MIA 19055	13 March 2020	Ongoing
Wholesaler Distribution Licence WDA(H)	19055 version 03	21 July 2014	Ongoing
Investigational Medicinal Products MIA(IMP)	MIA(IMP) 19055, version 17	12 December 2005	Ongoing
United Kingdom Controlled Drug Licence	345102	11 May 2018	10 May 2019 (renewal submitted, awaiting confirmation of new expiry date)
Authorisation to receive duty free spirits	DFS/020537	23 December 2016	Ongoing
Industrial denatured alcohol (IDA)	DNA/138430	11 July 2016	Ongoing
GDP Compliance of a Wholesale Distributor	UK WDA (H) 19055 Insp GDP 19055/431097-0008	Inspection 27 June 2016, issued 01/12/2016	Ongoing
Certificate of GMP Compliance of a Manufacturer UK MIA (IMP)	UK MIA (IMP) 19055 Insp GMP/IMP 19055/431097-0007	Inspection 28 June 2016, issued 03/11/2016	Ongoing

On a day to day basis, HPS is run by a Senior Management team headed by a Managing Director who in turn reports into the Trust's Finance Director; the Senior Management Team meets at least once a week formally and at other times on a specific project by project basis. The board of HPS consists of the Senior Management Team, the Trust Finance Director (also the board chair) and a Trust Non-Executive Director. Board meetings are held every two months although management and financial reports are produced on a monthly basis and the Managing Director and Trust Finance Director meet monthly. The current board governance structure is given below and the names of those in post (as at 31st March 2020)*.

Figure 1: HPS Governance structure



*Post period, Roger Brookes is no longer in post and a new Head of Production has been recruited to commence employment from Sept 2020.

3. Workforce

The make-up of the HPS board was unchanged with the current Managing Director and Head of Quality having completed their 4th and 10th years in post respectively during FY20.

Staff in post at the commencement and end of FY20 numbered 63 and 69 respectively. On a whole time equivalent basis, HPS employed 64.71 WTE at the beginning of FY21 (an increase of 7.971 WTE's during FY20).

Table2: HPS staff numbers

	End of				
	FY16	FY17	FY18	FY19	FY20
No. staff in post (SIP)	56	64	63	62	69
No. WTE	51.45	59.60	58.44	57.72	64.71
Annual staff turnover rate	4.16%	5.38%	6.27%	4.50%	8.78%

Of particular note during FY20 HPS recruited to a number of newly created positions across the business. A Clinical Trials Executive was appointed to help project manage and deliver the increasing number of contracts being won in this area (managed by the head of regulatory and clinical affairs), "floating" resource (one FTE) was added to our production areas to help improve resilience and we also established our own Project Management Office (PMO) following the appointment of an experienced Project Manager to oversee the efficient delivery of all projects at HPS. Key posts that were vacant at commencement of FY20 were all successfully filled during FY20.

Overall, the staffing structure (figure 2) remained largely unchanged from previous years with manufacturing and production being delivered through teams working in the distinct operational areas of sterile, non-sterile and tablet packing; staff in these areas were supported by teams from regulatory, clinical trials, quality (including new product development), customer services, warehousing and cleaning (see table 3 below for staffing number splits by function).

Figure 2: HPS staffing by band

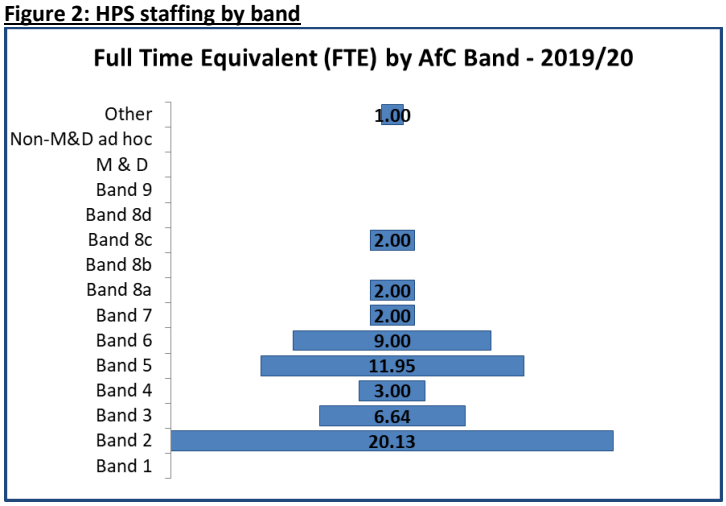


Table3: HPS staff numbers by function (March 2020)

Function	SIP	WTE
Sterile production	15	13.71
Quality Control and Assurance	12	11.57
Sales, customer services and warehouse	11	10.20
Non-Sterile Production	8	7.20
Tablet packing	7	6.43
New product Development	6	5.60
Cleaning/domestics	4	4.00
Senior Management Team	3	3.00
Clinical Trials	1	1.00
Regulatory Affairs	1	1.00
Project Management	1	1.00
Total	**69**	**64.71**

SIP=staff in place, WTE = whole time equivalents

Appraisals and mandatory training: At the commencement of FY21, HPS reported 100% completion of staff appraisals covering FY20. Mandatory training completion rates ranged from 85.71% to 100% across the 9 training requirements.

Sickness: At the end of FY20, HPS had an annual sickness rate of 3.90% (long term 2.05%, short term 1.85%) versus a Trust target rate of approx. 4.00%; the estimated cost to HPS of this sickness was £92K.

Staff survey: During FY20 HPS received staff feedback arising from the Trust wide staff survey and accordingly further consulted with colleagues and then fully implemented a program of change and recommendations which was overseen by the board of HPS.

4. Finance

During FY20 HPS delivered income of £15.3m and returned to the trust a contribution of £3.4m. As is shown below (table 4), HPS demonstrated significant actual year on year growth; reported revenue increased by 23.4% and reported contribution by 17.2%.

Table 4: HPS financial results FY20

	FY16	FY17	FY18	FY19	FY20
Income	£7.1m	£7.8m	£9.8m	£12.4m	£15.3m
Contribution	£2.2m	£2.3m	£2.8m	£2.9m	£3.4m

The main contribution generating functions within HPS during FY20 were sterile and non-sterile production, tablet packing and wholesaling. Furthermore, from a cost perspective staff continue to contribute to the process of reviewing all business expenditure (for example, historic plant and equipment maintenance contracts which were identified as an area of review in-order to decrease operational cost).

Revenue wise, sales were split across our functions as set out below (table 5) during FY20.

Table 5: HPS revenue analysis FY20

Function	% of FY17	% of FY18	% of FY19	% of FY20
Tablet packing	29.8%	42.9%	29.9%	27.0%
Sterile production	36.9%	25.4%	21.4%	14.7%
Non sterile production	27.0%	20.2%	16.8%	14.2%
Contract manufacturing*	-	6.3%	4.6%	2.6%
Wholesaling	-	2.0%	24.2%	38.3%
Contract research	3.0%	1.0%	0.1%	0.2%
Clinical trials	-	0	0.9%	1.1%
Others**	3.3%	2.2%	2.1%	1.9%

* Included in sterile production figures in FY17

** Delivery charges and small order handling charges

Agency spend: There was no spend on agency at close of FY20 and there is no planned agency spend for FY21.

Capital Expenditure: During period HPS drew a total £109K of capital spend (£795K in FY19) to purchase a new weighing management system (£93.6K, previous system was no longer serviceable) and to replace filters used in our depyrogenation oven (£15.4K, Lytzen filters).

Aged debt: The aged debt position for the unit deteriorated by £170K from period opening and closing values of £1.72m and £1.89m respectively, mostly due to the significant increase in trading experienced during the year. That said, the senior team monitor aged debt on a monthly basis and continue to pursue mitigation measures such as requesting card payment at the point of customer order and a formal process of debt "chasing" where customers have had accounts put on stop until monies owed have been paid.

Table 6: HPS aged debt position FY20

	FY17	FY18	FY19	FY20
Period opening value	£0.92m	£1.08m	£1.32m	£1.72m
Period closing value	£1.08m	£1.32m	£1.72m	£1.89m
Change in period	+£160K	+£240K	+£440K	+£170K
Current debt (%)*	61%	52%	33%	26%

*invoices issued that are less than 30 days old

5. Business activity and strategy

Historically, HPS has supplied product to every NHS Trust in the UK. During period, HPS traded with 255 NHS organisations and approximately 325 private companies (mainly corporate/independent pharmacies). Some 43% of revenue was derived from NHS organisations; revenue originating from private customers increased from 52% (FY19) to 57% in FY20. Based on our underlying strategy, we anticipate that over the coming years the share of revenue from the private sector will further increase due to HPS diversifying into contract research and manufacturing (where the customer typically will be pharmaceutical companies), clinical trials, licensing of products, wholesaling of pharmaceutical products and exporting (of licenced medicines) etc.

In February 2018 HPS presented a revised strategy and investment plan geared towards significantly growing contribution over the next six year period (FY19-FY25), which after review, was endorsed by the board of CHFT. As a result of this approval, work is on-going to identify investment sources required to deliver strategic objectives.

HPS throughout FY20 pursued and delivered a business strategy that sought to enhance or develop sales in the following areas;

i) Maximise sales of existing products (across sterile, non-sterile and tablet packing)
ii) Obtain Licences (marketing authorisations) for existing products
iii) Manufacture new products where competitors can no longer service the market (opportunity lead sales)
iv) Introduce new products where demand and a business case have been proved
v) Contract manufacturing for third parties
vi) Contract Research for third parties
vii) Clinical Trial supplies (the manufacture of investigational medicinal products and sourcing of clinical trial comparators)
viii) Wholesaling of medicinal products

Overall, the strategy is proving to be successful with the unit now having identified and developed a strong pipeline of licensable products which are being progressed through regulatory licensing/approval procedures. Accordingly, HPS established an in-house medicines regulatory function during FY19 and FY20 with the recruitment of an industry experienced regulatory affairs manager that will provide internal expertise and expedite the process to apply for marketing authorisations (MA's, i.e. licences that allow HPS to manufacture specific medicines).

Looking forward and following successfully obtaining a licence to manufacture non-sterile licenced products (during FY20) HPS is planning to submit a minimum of two applications for marketing authorisations/licences for specific medicinal products during FY21.

Clinical Trials: The manufacturing of medicines to be used in clinical trials (investigative medicinal products (IMPs) and related services to deliver clinical trials was a business area that HPS did not actively participate in two years ago. However, in-line with our 6 year strategy this was identified as a business opportunity for HPS and accordingly through renewed focus and recruitment of delivery resource HPS has enjoyed significant success during FY20 wining further work to deliver clinical trial services to the NHS, academia and industry.

The above mentioned contract wins represent a major step towards HPS becoming a recognised partner and supplier of medicines for use in clinical trials. At the time of writing the pipeline of opportunities in clinical trials is becoming material and HPS is in the latter stages of winning a number of similar contracts.

Engagement with clinicians: The unit continues to increase its visibility and interactions with clinical colleagues based at CHFT and the wider region, which has resulted in a number of new products currently being developed that will be launched in FY21/22. Such activity forms a sound basis for the future growth of HPS.

Accordingly, HPS will continue business activity in the above areas and commences FY21 with a strong sales pipeline.

6. Forward plan and strategy for FY21

Looking forward HPS has embarked upon FY21 with a similar strategy as that set out above for FY20 and we expect to report significant progress against each strategic aim during the course of the coming year. In particular during the course of FY21 HPS is intending to submit applications to obtain MAs for specific medicines. Equally important (and fundamental to ensuring the future performance of HPS) is obtaining financing that allows the delivery of identified strategic objectives.

5. Audit and Risk Committee Annual Report

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3 September 2020
Meeting:	Board of Directors
Title:	Audit and Risk Committee Annual Report 2019/20
Author:	Andrea McCourt, Company Secretary
Sponsored By:	Andy Nelson, Audit & Risk Committee Chair
Previous Forums:	Audit and Risk Committee 4 July 2020

Actions Requested:

- To note

Purpose of the Report

The Audit and Risk Committee is key in ensuring financial and corporate governance arrangements within the Trust are effective.

This paper presents the annual report of the Audit and Risk Committee for 2019/20 which details the role of the Audit and Risk Committee including membership and attendance and describes the activities of the Audit and Risk Committee during the year in line with the duties within the terms of reference.

Key Points to Note

It is good practice to summarise Committee activity over the past 12 months. This annual report is presented for information and assurance.

In 2020/21 Board Committee reports will be presented to the Audit and Risk Committee in advance of the Board, enabling the Audit and Risk Committee to fulfil its duty in reviewing the work of other Board Committees as part of its assurance role.

Recommendation

The Board is asked to note the assurances in the Annual Report that the Audit and Risk Committee met its duties for 2019/20.

Audit and Risk Committee Annual Report 2019/20

This annual report of the Audit and Risk Committee for 2019/20 details:

- The role of the Audit and Risk Committee including membership and attendance
- The activities of the Audit and Risk Committee.

1. Role of the Audit and Risk Committee

The role of the Audit and Risk Committee is to provide assurance to the Trust Board regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

1.1 Background

It is a formal requirement for all NHS Trusts to have an Audit and Risk Committee. Information about the appropriate operation of the Audit Committee is set out in the official *NHS Audit Committee Handbook* (Fourth Edition) published in 2018. The Audit and Risk Committee adheres to this guidance.

This report describes the Audit and Risk Committee's activities from April 2019 to March 2020 and in particular various matters for which the Audit Committee has oversight for the Board including:

- Financial reporting
- Risk management
- External audit
- Internal audit
- Governance arrangements.

The Chair escalates those matters that the Audit and Risk Committee considers should be drawn to the attention of the Board when the minutes of the Committee's proceedings are shared at the next meeting of the Board.

1.2 Terms of Reference

The Committee has an approved terms of reference in place. The Committee approved its terms of reference on 17 July 2019, with ratification by the Board on 5 September 2019. The Committee meets on a quarterly basis, with an additional meeting for the review of the annual report and accounts.

The Audit and Risk Committee has a well-established workplan which sets out its annual cycle of work and reporting which is regularly reviewed. The workplan for 2019/20 is attached at Appendix A.

1.3 Audit and Risk Committee Membership and Attendance in 2019/20

The Audit and Risk Committee met five times during 2019/20: 17 April, 21 May, 17 July, 30 October 2019 and 29 January 2020.

The membership of the Audit and Risk Committee is three Non-Executive Directors and the meetings were always quorate. A governor is invited to attend and observe each meeting,

Richard Hopkin was Audit and Risk Committee Chair until 31 December 2019 until he took up the role of Senior Independent Non-Executive Director and remains a member of the Committee. Andy Nelson, Non-Executive Director was appointed as Chair of the Committee from 1 January 2020 onwards.

The outgoing Non-Executive Director Linda Patterson's tenure ended in December 2019.This role was taken up by Denise Sterling, Non-Executive Director and Quality Committee chair, who attended meetings from 30 October 2019.

After each meeting, the Chair reported back to the next Trust Board meeting, drawing attention to those matters of significance for the Board. The draft minutes of the meetings are received by the Trust Board.

The following were in regular attendance at the Audit and Risk Committee meetings during the year:

- Gary Boothby, Director of Finance
- Mandy Griffin, Managing Director of Digital Health
- Kirsty Archer, Deputy Director of Finance
- Andrea McCourt, Company Secretary
- Clare Partridge, External Audit Partner, KPMG
- Helen Kemp-Taylor, Head of Internal Audit, Audit Yorkshire
- Leanne Sobratee, Internal Audit Manager, Audit Yorkshire
- Adele Jowett, Local Counter Fraud Specialist

The following also attended for specific items:

- Zoe Quarmby, Assistant Director of Finance – Financial Control for the annual accounts 2018/19
- Peter Keogh, Assistant Director of Performance, for assurance on data quality process following an external review

2. Audit and Risk Committee Activities 2019/20

The principal activities of the Audit and Risk Committee during 2019/20 are detailed below.

2.1 Financial Governance

Financial Reporting - Annual Report and Accounts for 2018/19
The Committee reviewed assurances relating to processes and previous audits to support the Trust reference cost submission.

The Committee considered the draft Annual Report and Accounts for 2018/19 and made a recommendation to approve to the Board meeting on 24 May 2019. This included accounts for the wholly owned subsidiary, Calderdale Huddersfield Solutions for the first time.

Standing Financial Instructions /Standing Orders
The Committee reviews in year the Standing Financial Instructions and Scheme of Delegation.

In response to the Covid-19 pandemic changes were proposed to the Standing Financial Instructions during March 2020 – these were formally approved by the Audit and Risk Committee on 7 April 2020.

The Committee regularly reviewed waivers of Standing Orders and approved losses and special payments.

2.2 External Audit

KPMG is the Trust's external auditor. The Committee reviewed the annual accounts as part of its audit for 2018/19, including final audit reports and management letters. It was noted that an impairment over the revaluation of assets, due to changes in valuation rules, had a material impact on the 2018/19 accounts, with an adjustment made. The going concern position was reviewed and KPMG noted a material uncertainty in this respect in their Audit opinion. The Committee also noted that changes to finance systems and the establishment of the wholly owned subsidiary had led to challenges in the 2018/19 audit work. A qualified value for money opinion for 2018/19 was given because the Trust had not accepted the 2018/19 financial control total.

The review of the Quality Accounts 2018/19 by external auditors resulted in a qualified limited assurance opinion due to issues with the 4-hour A&E waiting time indicator. Further information on assurance in relation to this is given in section 2.6.

The Committee reviewed and approved the External Audit Plan and annually reviews the performance of the external auditors.

The three year contract period for external audit was reviewed as we were into the third year of the contract. In line with national guidance it was agreed to extend KPMG period of appointment as external auditor by 1 year. This was formally signed off at the first Audit and Risk Committee in 2019/20 with the support of the lead governor on behalf of the Council of Governors.

External auditors also briefed the Committee at each meeting on sector related matters of interest.

2.3 Internal Audit (IA)
The Trust purchases internal audit services from Audit Yorkshire to review the adequacy of controls and assurances in place via a comprehensive audit programme. The Committee reviewed and approved the Internal Audit strategy, annual plan and detailed programme of work for 2019/20, which embraced operational as well as financial and business areas.

The annual Head of Internal Audit Opinion confirmed significant assurance regarding the system of internal control in the Trust.

The Committee received 27 finalised reports during the year with 2 high assurance opinions, 20 significant assurance opinions, 4 limited assurance opinions and 1 advisory report. The four internal audits which received limited assurance related to governance in the medical division, ensuring all patient correspondence is received by GPs, estates managed expenditure for minor works and end of life care. Each report includes recommendations and an action plan, agreed with management, with target dates for each action. .Internal Audit provides a progress report at each committee meeting which enables the committee to monitor progress against the actions.

It is noted that completion of the 2019/20 Internal Audit Operational Plan was impacted as a result of Covid-19.

The Committee annually reviews the performance of the internal auditors in year and to date this has been satisfactory.

2.4 Counter Fraud
The Trust takes the prevention and detection of fraud very seriously and the Counter Fraud Specialist continues to work to raise the profile of fraud in the Trust, explores the potential for fraud and investigates cases of fraud. In April 2019 the Local Counter Fraud Specialist (LCFS) provided a short presentation to the Committee on fraud risks in the Trust which included bribery, conflicts of interest, invoice fraud and working elsewhere whilst claiming sick pay. Attention was also drawn to the importance of declarations of interest and personal relationships.

The Committee received and approved the 2019/20Counter Fraud plan, regular progress reports and updates against this plan and the annual Counter Fraud report for 2018/19.

The Counter Fraud Specialist attended all meetings, except for the annual report and accounts meeting.

2.5 Risk Management
During the year, the Committee continued to review the risk management approach across the Trust, including a review of the Risk Management Strategy and Risk Management Policy.

The Board Assurance Framework (BAF) was reviewed twice, in October 2019 and January 2020. Following a Board workshop on the BAF in December 2019 the dates for the presentation of the BAF to the Committee were revised to allow for review of the BAF by the Committee before being presented to the Trust Board.

The Head of Internal Audit significant assurance opinion, for both 2018/19 and 2019/20, confirmed the BAF was regularly reviewed and updated by the Board of Directors and by its sub-committees, with a pro-active and accountable process in place for developing and updating the BAF.

2.6 Assurances Received by the Committee
In addition to usual business, the Committee received the following assurances during the year:

- **Clinical Audit Programme** – recognising the need for the Committee to be assured about the systems in place to support high quality care as a key component of good governance, the Chair of the Quality Committee provided an overview of the Clinical Audit Programme to the 17 July 2019 Committee meeting, describing arrangements for national and local audits. The Committee concluded that the review of clinical audit processes and national benchmarking rated the Trust good in most areas.

- **Data quality review** – given the qualified limited assurance opinion from External Audit in the 2018/19 quality accounts on the A&E 4 hour waiting time quality indicator, the Committee commissioned Internal Audit to undertake work in respect of the A&E Waiting target; the issue being that a clear audit trail was not being maintained in the patient records section of EPR. Following this work a significant assurance opinion was issued by Internal Audit. Assurance was given at the 17 July 2019 Committee meeting that, following management actions taken, the 4-hour A&E waiting time was now being recorded correctly

  On 29 January 2020, the Committee received a data quality report providing strong assurance regarding the Trust's data quality processes which had been commissioned from an external organisation.

- **Risk Management Review -** The Committee received a presentation on risk management over the previous 12 months which included:

  - a review of benchmarking of the Board Assurance Framework
  - a review of the high level risk register, noting risk movement (new and closed risks and changed risk scores), which provided assurance that the high level risk register was a dynamic document, with a focus on quality and safety risks
  - assurance that governance arrangements for management of risks for Calderdale Huddersfield Solutions (CHS) were in place.

- **Theatre Stocktake** – continued to be an issue of concern to the Committee and a task and finish group was established. At the meeting of 29 January 2020 assurances were given that actions had been agreed to improve the quality of the theatre stocktake.

- **Cyber Security Deep Dive –** on 29 January 2020 the Committee noted significant assurance from the Managing Director for Digital Health following an internal audit review regarding cyber security. However, the Committee also noted the need to continue to be vigilant given the ever-evolving threat and the need for funding to be fully compliant with the NHS Standard Data Security Protection Toolkit.

2.7 Areas Noted by the Committee

- **Treasury Management** - it was noted that, for the first time, the 2018/19 Treasury Management annual report reflected the wholly owned subsidiary, with the treasury management function for Calderdale and Huddersfield Solutions provided by the Trust under a contract arrangement.

- **St Luke's accounting transactions** - at its meeting on 30 October 2019 the Committee reviewed and noted, on behalf of the Board, the accounting treatment of both the disposal of the land at St Luke's and the existing accounting treatment for the investment in the Joint Venture, Pennine Property Partnerships (PPP).

- **Third party assurance mapping –** in response to the Committee's self -effectiveness action plan identifying a gap relating to third party assurance mapping, the Committee received a report listing the third-party bodies with which the Trust co-operates, some statutory and some non-statutory, noting further work to develop the report would be desirable.

2.8 Governance and Reporting Groups

The Committee reviewed and approved changes to the Board Committee arrangements and reporting groups to the Audit and Risk Committee.

In year reporting to the Committee from the following sub-groups took place:

- Information Governance and Records Strategy Committee
- Risk and Compliance Group
- Health and Safety Committee
- Data Quality Board

The Committee discussed how best assurance could be provided to the Committee and the Board regarding the work of the Health and Safety Committee given that there is not capacity for a Health and Safety colleague to attend the Audit and Risk Committee. It was noted that in addition to receipt of minutes at the Committee an annual update is provided to the Board on Health and Safety. This was provided to the 9 January 2020 Board meeting, where a programme of regular updates to the Board on health and safety was agreed. The Committee will also do an annual deep dive into the work of the Health and Safety Committee.

At its 29 January 2020 meeting the committee also agreed that a summary report should accompany the minutes of each reporting sub-group from April 2020 onwards. Due to Covid-19 this will commence from the meeting of 22 July 2020.

3. Review of Committee Effectiveness

On an annual basis the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place in February 2020 and the outcome of this was deferred to the meeting of 22 July 2020 due to the focus on urgent matters during the Covid-19 pandemic in April 2020.

4. Conclusion

As described above, the Audit and Risk Committee has received assurance through the course of 2019/20 from management, other assurance committees, the risk management processes and progress reports from counter fraud, external and internal audit.

The Audit and Risk Committee therefore confirms that it has fulfilled its role of providing assurance to the Board during 1 April 2019 to 31 March 2020 regarding the monitoring and review of financial and other risks and associated controls, corporate governance and the assurance frameworks of the Trust and its subsidiaries.

Audit and Risk Committee Chair
15 July 2020

Andy Nelson Non-Executive Director, Audit and Risk Committee Chair
Andrea McCourt, Company Secretary

2019/20 Audit & Risk Committee workplan – see below

Date of meeting	15 Jan 2019	15 April 2019	May 2019 (ARA)	15 July 2019	21 Oct 2019	COMMENTS
Date final reports required						
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	
Declarations of interest	✓	✓	✓	✓	✓	
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	
GOVERNANCE						
Review the Board Assurance Framework	✓			✓		
Review the risk management system					✓	As required
Review the Annual Governance Statement		✓				
Review the Trust's Annual Report			✓			
Review standing orders / standing financial instructions/Scheme of Delegation	✓ (Review SFI) (Review SO re conflicts of interest)	✓				
Review Code of Governance compliance		✓				
Review ARC Workplan	✓	✓		✓	✓	
Approval of appropriate policies - Standards of Business Conduct - Declarations of Interest - Counter fraud - Risk Management					✓ (review progress re Declaration of Interests) & Risk Management Policy	
Note business of other committees and review inter-relationships - Risk & Compliance Group - Information Governance & Risk Strategy Committee Minutes - Data Quality Board - Health and Safety Group	✓	✓		✓	✓	

Regulatory Compliance					✓	Annual review
Declaration of Interests and Standards of Business Registers & Policy (as approp)					✓	Annual review
Review Terms of Reference for sub committees		✓				Annually – Feb –April 2020
FINANCIAL FOCUS						
Agree final accounts process and plans	✓					
Review going concern report			✓			
Review audited Annual Accounts and financial statements			✓			
Receive draft letter of representation			✓			
Review losses and special payments	✓	✓		✓	✓	
Waivers of standing orders report	✓	✓		✓	✓	
Receive Treasury Management annual report		✓				
INTERNAL AUDIT						
Review Follow-up Report	✓	✓		✓	✓	
Review and approve internal audit plan		✓				
Review internal audit progress report	✓	✓		✓	✓	
Receive internal audit annual report			✓			
Review of effectiveness of internal audit		✓				
Receive Head of Internal Audit Opinion			✓			
EXTERNAL AUDIT						
Agree external audit plans and fees	✓					
Review of the external audit (re-tender)		✓				
Receive external audit sector update	✓	✓		✓	✓	
Receive ISA 260/long form audit report			✓			
COUNTER FRAUD						
Review and approve counter fraud annual plan		✓				

Receive counter fraud progress report	✓	✓		✓	✓	
Receive counter fraud annual report				✓		
Review of effectiveness of counter fraud arrangements		✓				
LCFS Risk Assessment		✓				
Anti-Fraud, Bribery and Corruption Workplan		✓				
AUDIT & RISK COMMITTEE – GENERAL						
Self-assessment of committee effectiveness	✓ (issue)	✓ (collate)				
Attendance Register		✓				
Review of Terms of Reference				✓		
Produce Annual Committee Report (for CoG)		✓				
Set and review committee annual workplan audit		✓			✓	
Private meeting with internal and external auditors			✓10.30-11.00			
Review Audit Chair & Job Description				✓		
Review of Meeting	✓	✓	✓	✓	✓	
Review ARC Meeting Dates		✓ (confirm May meeting date)			✓	

Audit and Risk Committee workplan 2019

6. Finance & Performance Committee Annual Report

NHS
Calderdale and Huddersfield
NHS Foundation Trust

Date of Meeting:	3 September 2020
Meeting:	Board of Directors
Title:	Finance and Performance Committee Annual Review 2019/20
Author:	Kirsty Archer - Deputy Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance and Performance Committee Audit and Risk Committee
Actions Requested: To note	
Purpose of the Report	
Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2019/20 setting out how it has met its Terms of Reference and key priorities.	
Key Points to Note	
The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from clinicians and managers outside the Committee. A self-assessment has been recently completed and an action plan will be formed in response to this feedback.	
EQIA – Equality Impact Assessment	
Individual decisions made by the committee during the course of the year will have been required to undergo a QIA and EQIA as appropriate	
Recommendation	
The Board is asked to note the attached summary	

Finance and Performance Committee
Annual Review 2019/20

1. Background

Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2019/20 setting out how it has met its Terms of Reference and key priorities.

The purpose of the Committee is laid down in its terms of reference. In summary it is responsible for providing information and making recommendations to the Trust Board on financial and operational performance issues and for providing assurance that these are being managed safely. This report will consider the work of the Committee over the course of the last 12 months against each of the key areas of responsibility as laid out in the terms of reference.

2. Finance and Financial Performance

Monthly reporting is provided to the Committee by way of a comprehensive pack of financial metrics and narrative on the year to date and forecast position against the plan for the year. This pack covers the activity, income and expenditure position including cost improvement programme (CIP), capital, cash and use of resources metric. The financial risks which form part of the overall Trust risk register are reviewed against the intelligence in this report and discussed by the Committee on a monthly basis. The financial elements of the Board Assurance Framework are also reviewed by the Committee against the in-year performance and longer-term outlook.

An overview of the Trust's financial deficit position was provided by a review into 'What might make us fiscally unique?' which was updated in the context of the 2019/20 plans. A specific piece of work discussed by the Committee, examined the actions that were being put in place to pro-actively transform patient pathways which were positive drivers of the trading position against the aligned incentive contract. The content of both of these reports was also shared with commissioners to support a system wide view.

The formation of a Use of Resources (UOR) action plan followed the UOR assessment by NHSI as part of the latest CQC inspection. The Committee received updates during the course of the year on progress against this action plan and ongoing work. Whilst one specific action was to evidence the return on investment following the implementation of the Electronic Patient Record (EPR), a full report on this was presented in June 2019. In addition, the Committee signed off the Trust's Reference Costs & Patient Level Cost Submissions 18/19 having reviewed the headline submission data and the process undertaken. This submission is key to informing future benchmarking data.

3. Performance Delivery and Assurance

The Committee receives the monthly Integrated Performance Report which is presented by the Trust's Chief Operating Officer who is able to draw out key messages from the

comprehensive report, highlighting particularly positive performance and areas of concern and management actions to maintain the former and address the latter.

In year a specific piece of work was carried out around the Referral to Treatment (RTT) Diagnostics Project for which the Trust had been chosen as a pilot site. This was reported to the Committee in November 2019. The conclusion of this report was that the RTT field testing and RTT diagnostic, in parallel, have enabled the trust to focus on good quality data and reducing the waiting times for those patients already past 18 weeks on their pathway. The impact of this work on the overall waiting list has been significantly mitigated by solid, high volume validation and wider learning highlighted the opportunity to translate this into a wider education plan for those entering data.

During the course of the year the Committee has requested a number of deep dives into specific clinical specialties or areas of performance which have been highlighted either as having challenges or opportunities. For example, Theatre Productivity, Radiology and Outpatient Performance. These areas have provided follow up reports which has enabled the monitoring of reporting against action plans. These presentations have been made directly to the Committee by the lead clinicians and managers who were able to bring the topics to life and answer questions which was well received by committee members. Similarly a Getting It Right First Time (GIRFT) presentation gave practical examples of where GIRFT initiatives had made an impact.

4. Business and Commercial Development

Trust's Long-Term Plan (5 year) was presented to the Committee in September at the draft submission stage and again in October in line with the final Trust submission to the ICS. This submission indicated that the 20/21 Financial Improvement Trajectory is in line with the Strategic Outline Case (SOC). Beyond this the indicative Financial Improvement Trajectory for the years 21/22 to 23/24 is less challenging than that assumed in the SOC and reflect revised national funding expectations.

The Committee's understanding of the Long-Term Plan set the context for the Operational Plan (1 year) draft submission for 20/21 to the ICS and NHSI in March 2020. The Committee reviewed this plan including the position on contract negotiations with commissioners and approved a plan submission in line with the Financial Improvement Trajectory acknowledging that the forthcoming year would be extremely challenging in terms of the CIP expectations and that the risk rating should reflect this. The capital plan was ratified by the Committee and formed part of the overall plan submission.

The Committee routinely receives the Board minutes and annual reports from the Trust's commercial areas, Huddersfield Pharmacy Specials and The Health Informatics Service. In addition, minutes are received from the Commercial Investment Strategy Committee and Capital Management Group detailing business case approvals, progress and expected deliverables.

5. Treasury Management

In April 2019 the Committee received a report on treasury management in 2018/19 which also highlighted points to note in relation to the 2019/20 plans. The report concluded that the cash position has been managed in 2018/19 through the challenges of the legacy working capital pressures that were carried forward from 2017/18, the financial IT system upgrade and the new arrangements around the wholly owned subsidiary. It was noted at this stage that the

cash position would remain challenged in 2019/20 and this would continue to be managed and monitored closely.

The in-year management and monitoring of treasury management has been reported to the committee through the monthly financial performance pack. This includes information on levels of borrowing, aged debt, performance against the Better Payment Practice Code. This information is routinely discussed and challenged by the Committee.

The activities undertaken through the Cash Management Committee are reported to the Committee through receipt of the minutes on a quarterly basis in support of the Committee's review of debtor ageing and credit control procedures.

6. Procurement

The Procurement service is provided under contract from Calderdale and Huddersfield Solutions (CHS). The Committee receives minutes on a quarterly basis from the CHFT/CHS Joint Liaison Committee.

The Committee received a presentation on Procurement in year reviewing the activities undertaken by the function, contributions to the Trust's cost improvement programme and position against national metrics.

7. Membership, Attendance and Monitoring Effectiveness

The Committee is held on a monthly basis and was quorate on 11 occasions of the last 12 meetings. The timing of the December (non-quorate) meeting limited potential attendance but the decision was taken to proceed with an informal information sharing meeting. A register of attendance is shown at Appendix 1.

A self-assessment questionnaire in relation to the effectiveness of the committee is carried out on an annual basis. The latest was completed in February 2020 and the responses were very positive. An action plan is to be agreed to address any specific comments raised at the next meeting of the Committee in March.

8. Summary and Recommendation

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from clinicians and managers outside the Committee. A self-assessment has been recently completed and an action plan will be formed in response to this feedback.

The Committee is recommended to note the contents of this report.

APPENDIX 1

FINANCE & PERFORMANCE ATTENDANCE – 2019/20

MEMBERS	Mar 29 Mar	Apr 26 Apr	May 31 May	June 28 June	July 26 July	Aug 30 Aug	Sept 27 Sept	Oct 1 Nov	Nov 29 Nov	Dec 31 Dec	Feb 3 Feb	Mar 2 Mar
Helen Barker, Chief Operating Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓	Phone	✓	✓
Anna Basford, Director of Transformation and Partnerships	✓	✓	✓	✓	✓	Apols	✓	✓	✓	Apols	Apols	✓
Gary Boothby, Director of Finance	✓	In part	✓	✓	Apols	✓	Apols	Apols	Apols	Apols	✓	✓
Owen Williams, Chief Executive Officer	✓	Apols	✓	✓	Apols	Apols	✓	✓	✓	Apols	✓	✓
Richard Hopkin, Non-Exec (Vice Chair / CHAIR from Dec 2019)	✓	✓	✓	✓	Apols	✓	✓	✓	Chair ✓	Chair ✓	✓	✓
Phil Oldfield, Non-Exec (CHAIR)	✓	✓	✓	✓	✓	✓	✓	✓	Apols			
Peter Wilkinson, Non-Exec								Apols	✓	Apols	Apols	✓
IN ATTENDANCE												
Kirsty Archer, Deputy Director of Finance (Member in place of Director of Finance, Sept to Dec 2019)	✓	✓	Apols	✓	✓	Apols	✓	✓	✓	✓	✓	✓
Sian Grbin, Governor	✓	Apols	✓	✓	Apols	✓	✓	Apols	Apols	Apols	Apols	✓
Philip Lewer, Trust Chair	✓	Apols	✓	X	✓	✓	✓	✓	✓	✓	✓	X
Andrea McCourt, Company Secretary	Apols	X	X	X	✓	Apols	✓	Apols	✓	✓	✓	✓

7. Quality Committee Annual Report

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 3rd September 2020
Meeting:	Board of Directors
Title of report:	Quality Committee Annual Report 2019/2020
Author:	Andrea Dauris, Associate Director of Quality and Safety Denise Sterling Non-Executive Director
Sponsor Director	Ellen Armistead, Executive Director of Nursing/Deputy Chief Executive
Previous Forums:	Quality Committee

Actions Requested
For assurance

Purpose of the Report

This annual report describes the activities of the Quality Committee between April 2019 and March 2020, describing how the Committee met the duties within the terms of reference. The report includes:

- Overview of the role of the Quality Committee
- Details of membership and attendance between April 2019 and March 2020
- Information of the work of the Committee in the following areas:

  - quality improvement
  - governance and risk / patient safety
  - audit and assurance
  - quality and safety reporting

- Effectiveness of the Committee – this section summarises the response of the self – assessment by members which reviewed the committee's focus and objectives, committee team working, committee effectiveness, committee engagement and committee leadership. Eight out of nine members completed the assessment, and the summarised findings can be found at the end of the report (appendix 1)

Key Points to Note

This annual report is presented for assurance purposes following approval from the Quality Committee on the 3rd August 2020.

EQIA – Equality Impact Assessment

All EQIA are a valuable method of internally scrutinising the Trust and everything that the Trust delivers, prior to external scrutiny from anyone including the Commission for Equality & Human Rights, the Care Quality Commission, and the Audit Commission.

It is not anticipated that this summary positions described within this report will have a detrimental impact on any of the protected characteristics

However, the EQIA is an ongoing process and should be repeated on a regular basis to make sure that the Trust is offering a service that meets legislation, encourages equal access for all and reduces as many negative impacts identified as possible in terms of its overall delivery of high-quality care
Recommendation
The Board is asked to note the assurances in the Annual Report that the Quality Committee met its duties for 2019/20

Quality Committee Annual Report 2019 / 2020

This Quality Committee annual report for 2019 / 2020 details:

- The role of the Quality Committee, membership and attendance between April 2019 and March 2020 and the terms of reference
- The activities of the Quality Committee between April 2019 and March 2020
- Self- assessment of the effectiveness of the committee

1. Introduction

1.1 Purpose of the Quality Committee

The purpose of the Quality Committee is to provide assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care; and to ensure that the risks associated with the quality of the delivery of patient care are managed appropriately.

The Quality Committee is also responsible for reviewing proposed quality improvement priorities, monitoring performance and improvement against the Trust's quality priorities, the implementation of the Quality Account, and ongoing monitoring of compliance with national standards and local requirements.

The Quality Committee receives assurance from a number of quality sub-groups via an annual work plan structured around the CQC domains.

1.2 Terms of Reference

The Committee has approved terms of reference in place.

The terms of reference were reviewed by the Committee in January 2020, and amended in June 2020, with the changes being:

- Organ Donation Committee removed from sub-groups
- Cancer Board added to sub-groups
- Amendment of named Non-Executive Director / Chair
- Frequency of Medication Safety and Compliance Group changed from quarterly to monthly
- Clinical Director of Pharmacy added to membership
- Executive Director of Workforce and Organisational Development amended to Deputy Director of Workforce and Organisational Development

1.3 Quality Committee Membership and Attendance in 2019/2020

The Quality Committee met twelve times between April 2019 and March 2020.

The membership and attendance at the Quality Committee between April 2019 and March 2020 is given below, with one member of the Council of Governors invited to attend and observe each meeting.

Name	Role	Number of meetings attended
CORE MEMBERS		
Denise Sterling [1]	Non-Executive Director **(Chair)**	6 / 6
Ellen Armistead [2]	Chief Nurse	7 / 9
Dr. Sarina Beacher [3]	Interim Associate Director of Quality and Safety	3 / 3
Dr David Birkenhead	Medical Director	10 / 12
Jason Eddleston	Deputy Director of Workforce & Organisational Development	5 / 12
Karen Heaton	Non-Executive Director **(Vice-Chair)**	10 / 12
Anne-Marie Henshaw [4]	Associate Director of Quality and Safety	7 / 9
Christine Mills	Council of Governors	11 / 12
Lindsay Rudge	Deputy Chief Nurse	6 / 11
Maxine Travis [5]	Senior Risk Manager	8 / 10

1 Member from January 2020
2 Member from July 2019
3 Member from January to March 2020
4 Member to December 2019
5 Member from 3 June 2019

Name	Role	Number of meetings attended
DIVISONS (one meeting per quarter)		
Surgery & Anaesthetics	Associate Director of Nursing	4 / 4
Medical	Associate Director of Nursing	4 / 4
Families & Specialist Services	Divisional Director / ADN	4 / 4
Community Healthcare	Associate Director of Nursing	4 / 4

2. Quality Committee Activities 2019 / 2020

The principal activities of the Quality Committee during April 2019 and March 2020 are detailed below within the areas of quality improvement, risk, patient safety, audit and assurance and quality and safety reporting from sub-groups:

2.1 Quality Improvement

The Quality Committee reviewed the following areas during the year to gain assurance regarding service quality and improvement:

- **External agency visits, inspections and accreditations**
  This was presented in June 2019 as part of the quarter 3 quality report presented in February 2020, which highlighted visits from the Neonatal Network Peer Review (October 2019); Neurophysiology IQUIPs visit (26 November 2019); ISAS Radiology Accreditation (Online submission in December 2019); National Bowel Cancer Screening Programme (27 and 28 November 2019); Cellular Pathology and Mortuaries UKAS ISO 189 (3 and 4 December 2019), and British Association for Cardiovascular Prevention & Rehab (BACPR) / National Audit of Cardiac Rehab (NACR) (December 2019)

- **Learning from Deaths –** the Committee received the first update on the learning from death mortality review process in July 2019 and requested six-monthly updates thereafter. The report indicated an improving position, reporting compliance with national guidance, in addition to setting a revised target of 50% completion of initial screening reviews. The findings of the Internal Audit report on death certification were presented to the Committee in December 2019, indicating an overall grading of limited assurance. The Committee received updates on the plans to recruit into a Medical Examiner role whose scope will include addressing the shortfalls identified within the Internal Audit Report on Death Certification.

- **Outpatient Deep Dive** – This was received in July 2019 highlighting the improvement work in the outpatient's directorate. Examples of the improvement work included progress in the way in which performance data is reviewed and responded to within the clinical services. Changes in process related to the appointment systems and improved communication with patients where delays are expected. The Committee welcomed and noted the significant improvement work that had been undertaken in this area.

- **CQC –** the Quality Committee continues to have oversight of improvement work to address CQC recommendations and to ensure essential standards are embedded across the organisation via the CQC Response Group.

- **Complaints Deep Dive** – An update was initially received in July 2019, with a further update provided in September 2019 and March 2020 updating on progress made with the complaints performance. The annual complaints report was also received in July 2019.

- **Quality Accounts in the Emergency Department** – This report was received in September 2019 outlining the discrepancies in patients not being discharged in real time. Assurance was provided that work is being undertaken to ensure capacity in order to report discharges in real time. This issue was also discussed at the Annual General Meeting in July 2019, where no issues or concerns were raised.

- **Mental Health Strategy** – verbal updates were provided on the Mental Health Strategy, and a draft version was presented in March 2020. The training plan amended terms of reference and Policy for mental health will be presented at a future Quality Committee meeting.

- **Friends and Family Test (FFT) Changes** – Forthcoming changes to the FFT were presented in November 2019, with the new arrangements being implemented from 1 April 2019. Progress on the changes will continue through the Patient Experience and Caring Group, which will provide further updates to the Quality Committee.

- **Getting it right first time (GIRFT)** – an initial update was provided in September 2019 outlining the positive feedback and recognition, both regionally and nationally with the process. A further update was provided in March 2020 updating on a positive report and the Trust being at the forefront nationally with this process and engaging with other organisations.

2.2 Risk / Patient Safety

Risk / Patient Safety

The Committee continued its focus on patient safety and risk management which included:

- *Risks* – Regular reviews of the high-level risk register and board assurance framework to ensure that all risks relating to quality and safety were identified and being managed to mitigate the risks.

- *Patient Safety / Serious incidents* – The serious incident annual report was reviewed in July 2019, as well as regular updates on the governance of outstanding actions from completed serious incidents. Regular updates on new serious incidents and summaries of completed serious incident investigations were received, identifying recommendations to improve care.

- *Healthcare Safety Investigation Branch (HSIB)* – Regular updates were provided on actions from investigations received. An update from the FSS division was also received in December 2019 summarising five Healthcare Safety Investigation Branch incidents. An overarching action plan is yet to be presented to the Quality Committee.

2.3 Audit and Assurance

The Committee received benchmarking comparisons with other Trusts in relation to clinical audits on maternal, newborn and infant clinical outcome review programme, bowel cancer audit, lung cancer audit, paediatric diabetes audit, national vascular registry, emergency laparotomy audit and hip fracture audit. The blood glucose diabetes control (HbA1c) on the paediatric diabetes audit was showing as an outlier, and the FSS division were asked to review the data and provide an update on what is being done. This was provided as part of their Patient Safety and Quality Board report at the meeting on 3 June 2019.

2.4 Quality and Safety Reporting

Patient Safety and Quality Board (PSQB) Reporting

Four of the Quality Committee meetings during the year were dedicated to seeking assurance from divisions on the effectiveness of divisional governance via quarterly PSQB reports to the Quality Committee during 2019/2020 from the Medical division, Surgery and Anaesthetics division, Family and Specialist Services division and Community Healthcare division.

Reports from Sub-groups

The following groups reported to the Quality Committee by providing progress reports during the year as detailed in the work plan:

- Patient Experience and Caring Group
- Patient Safety Group
- Clinical Outcomes Group / Clinical Improvement Group
- Serious Incident Review Group
- Medication Safety and Compliance Group
- Cancer Board Report
- Safeguarding Report
- Infection Control Committee
- Research and Innovation Report

Quarterly Quality reports – these were received on a quarterly basis, and in February 2020, it was agreed that the amended reporting format and assurance statements provided will continue for future reports.

Quality Account - The timeline for the production of the Trust quality account 2019/2020 was presented in February 2020. NHS England subsequently revised this timeframe following declaration of the Covid-19 pandemic in March 2020.

3. Effectiveness of Quality Committee

On an annual basis, the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place in June 2020 (Appendix 1), the action plan will be developed at a future meeting.

4. Conclusion

As described above, the Quality Committee has received assurance through the course of 2019/2020 from a number of sources including external agency visits, accreditation programmes and sub-groups of the Committee.

The Committee therefore confirms that it has fulfilled its role to the Board during 1 April 2019 to 31 March 2020 in fulfilling its key functions of providing assurance that that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care. In addition to ensuring that the risks associated with the quality of the delivery of patient care are managed appropriately.

5. Next Steps 2020 / 2021

In drawing this report together, it is necessary to give context as the Covid-19 pandemic was declared in March 2020. Looking forward, the Trust had to make significant adjustment to how it operates in order to ensure resources are channelled into the emergency response. A governance structure was put in place to reflect the needs of the organisation during this phase, much of which has been around the specific quality and safety challenges that manifest as a result of managing a pandemic.

The Trust has needed to operate very differently, including streamlining the functions of the Quality Committee to ensure there is ongoing oversight of the quality and safety agenda during the pandemic whilst at the same time responding to our pre-Covid priorities. In adopting a more streamlined approach the Quality Committee will continue to undertake its key function of ensuring the arrangements during the pandemic are effective in ensuring quality governance arrangements are maintained.

Denise Sterling
Non-Executive Director / Quality Committee Chair
July 2020

Appendix 1

Self – assessment of effectiveness of Quality Committee

Seven responses were received, and the findings are below:

- ***Committee focus***

  - The Committee has set itself a series of objectives it wants to achieve this year
    - Strongly agreed = **28.6 %**
    - Agreed = **71.4 %**

  - The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.
    - Strongly agreed = **100 %**

  - Committee members contribute regularly across the range of issues discussed.
    - Strongly agreed = **85.7 %**
    - Agreed = **14.3 %**

  - Sufficient time is given to both current year and forward planning in relation to finance, activity and performance
    - Strongly agreed = **85.7 %**
    - Disagreed = **14.3 %**

- ***Team Working***

  - The Committee has the right balance of experience, knowledge and skills.
    - Strongly agreed = **42.9 %**
    - Agreed = **57.1 %**

  - The Committee ensures that the relevant executive director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.
    - Strongly agreed = **57.1 %**
    - Agreed = **42.9 %**

  - Management fully briefs the committee via the assurance framework in relation to the key risks and assurances received and any gaps in control/assurance in a timely fashion thereby eradicating the potential for 'surprises'
    - Strongly agreed = **14.3 %**
    - Agreed = **85.7 %**

  - The sub-groups report timely and clear information in support of the committee thereby eradicating the potential for 'surprises'.
    - Strongly agreed = **14.3 %**
    - Agreed = **85.7 %**

  - I feel sufficiently comfortable within the committee environment to be able to express my views, doubts and opinions.
    - Strongly agreed = **100 %**

  - Members hold their assurance providers to account for late or missing assurances.
    - Agreed = **71.4 %**
    - Disagree **= 14.3 %**
    - Unable to answer **= 14.3 %**

- When a decision has been made or action agreed, I feel confident that it will be implemented as agreed and in line with the timescale set down.
  - Strongly agreed = **14.3 %**
  - Agreed = **85.7 %**

➢ ***Effectiveness***

- The quality of committee papers received allows me to perform my role effectively.
  - Strongly agreed = **28.6 %**
  - Agreed = **71.4 %**

- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.
  - Strongly agreed = **71.4 %**
  - Agreed = **28.6 %**

- Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.
  - Strongly agreed = **71.4 %**
  - Disagreed = **28.6 %**

- Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.
  - Strongly agreed = **57.1 %**
  - Agreed = **42.9 %**

- At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc
  - Strongly agreed = **71.4 %**
  - Disagreed = **28.6 %**

- There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.
  - Strongly agreed = **57.1 %**
  - Agreed = **28.6 %**
  - Disagreed = **14.3 %**

➢ ***Committee engagement***

- The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.
  - Strongly agreed = **28.6 %**
  - Agreed = **71.4 %**

- The committee is clear about the complementary relationship it has with other committees that play a role in relation to clinical governance, quality and risk management.
  - Strongly agreed = **28.6 %**
  - Agreed = **71.4 %**

- I can provide two examples of where we, as a committee, have focused on improvements to the system of internal control as a result of assurance gaps identified.
  - Strongly agreed = **42.9 %**
  - Agreed = **42.9 %**
  - Unable to answer = **14.3 %**

- *Committee leadership*

  - The committee Chair as a positive impact on the performance of the committee.
    - Strongly agreed = **42.9 %**
    - Agreed = **57.1 %**

  - Committee meetings are chaired effectively and with clarity of purpose and outcome.
    - Strongly agreed = **42.9 %**
    - Agreed = **57.1 %**

  - The committee Chair is visible within the organisation and is considered approachable.
    - Strongly agreed = **71.4 %**
    - Agreed = **28.6 %**

  - The committee Chair allows debate to flow freely and does not assert his/her own views too strongly.
    - Strongly agreed = **85.7 %**
    - Agreed = **14.3 %**

  - The committee Chair provides clear and concise information to the Board on the activities of the committee and the implications of all identified gaps in assurance/control.
    - Strongly agreed = **42.9 %**
    - Agreed = **42.9 %**
    - Unable to answer **= 14.3 %**

8. Update from sub-committees and receipt of minutes & papers

- Finance and Performance Committee meetings held 29.6.20 and 3.8.20
- Audit and Risk Committee held 22.7.20
- Quality Committee meetings held 29.6.20 and 3.8.20
- Workforce Committee meetings held 15.7.20 and 10.8.20
- COVID-19 Oversight Committee meetings held 29.6.20, 20.7.20 and 14.8.20
- Organ Donation Committee meeting held 15.7.20
- Council of Governors meeting held 9.7.20

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on
Monday 29 June 2020, 11.00am – 1.00pm
Via Microsoft Teams

PRESENT

Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Ellen Armistead	Director of Nursing / Deputy CEO
Helen Barker	Chief Operating Officer (In part)
Peter Wilkinson	Non-Executive Director
Richard Hopkin	Non-Executive Director (CHAIR)

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Philip Lewer	Chair
Sian Grbin	Governor
Stuart Baron	Associate Director of Finance

ITEM

075/20 WELCOME AND INTRODUCTIONS
The Chair welcomed attendees to the meeting.

076/20 APOLOGIES FOR ABSENCE
Apologies were received and noted for Owen Williams.

077/20 DECLARATIONS OF INTEREST
There were no declarations of interest to note.

078/20 MINUTES OF THE MEETING HELD 1 JUNE 2020
The Minutes of the meeting held 1 June 2020 were approved as an accurate record.

079/20 ACTION LOG AND MATTERS ARISING
009/19: Use of Resources (UOR) Update – The Deputy Director of Finance introduced a timeline of the latest plan to reinvigorate the UOR preparation work which will lead to an external review by Capsticks in October 2020. Internal work will continue to gather evidence which will be presented to WEB in September. In addition, the Director of Nursing has agreed to follow up with contacts at the CQC to try to identify likely timescales and the focus of the CQC inspection. It was noted that there had not been any major pushback from individuals in attending the Task & Finish groups, however, we should be mindful of fatigue and the capacity of our operational and clinical managerial colleagues.

ACTION: It was agreed that this item should come back to this Committee as per the timeline – **KA, verbal update 1/9/20 and an In-depth review 2/11/20**

088/19: Referral To Treatment (RTT) Final Close-down Report – The Chief Operating Officer updated the Committee that the Trust have halted the delivery against the RTT standard at the moment and are treating patients on a 'clinical need'

basis. It was suggested that a one-page update will be provided to the next meeting. It was noted that if/when the national programme recommences then a further report would be provided to the Committee.

ACTION: To present a one-page update regarding RTT following due-governance – **HB/PK, 3/8/20**

055/20, 059/20 & 065/20: HB suggested that the IPR will be agreed in terms of the KPIs by the end of August, which will include a focus on the KPIs to be managed through winter. It was agreed that all actions relating to IPR KPIs, Winter, the targets not historically achieved and a review of the overall system-wide position should be brought together as part of a Stabilisation and Re-Set Plan at the end of August – **HB, 1/9/20**

Recovery Workstreams/Outpatient Re-Set Workstream Update – A Stabilisation and Re-set Plan will be brought to this Committee which will align with the IPR – **HB, 1/9/20**

FINANCE & PERFORMANCE

080/19 MONTH 2 FINANCE REPORT

The Director of Finance stated that at Month 2 we are reporting a break-even position after assuming retrospective top up funding of £5.8m. It was noted that year to date the Trust has incurred £6.8m in relation to COVID, of which £2.4m relates to gowns which were purchased by the Trust on behalf of the region. The underlying position excluding COVID costs is a year to date favourable variance of £1.0m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.

The following headlines were noted:

- CIP is still being reported within the position and CIP achieved year to date is £0.64m, £1.8m lower than planned.
- Agency expenditure year to date is just below £600k which is significantly below plan.
- Cash balance is higher than planned due to contract payments being made in advance.
- Payments to suppliers are being made more frequently with more invoices being paid within 30 days compared to last year which has lead to our Better Payment Practice Code being much improved. However, the challenge for the Trust is the internal approval of invoices to enable invoices to be paid. As a result, a piece of educational work has been commissioned which will enable colleagues to understand their responsibility for the ordering and receipting of goods.

A question was asked regarding the re-introduction of car parking charges. It was noted that we are awaiting national directive, however, there are no immediate plans to re-introduce car parking charges. It was noted that as part of our Business Better Than Usual (BBTU) plans there is an opportunity to do something differently and an external piece of work is due to be commissioned which would review our existing car parking policy, this piece of work is due to be concluded by the end of September and will be reviewed with our Council of Governors.

It was noted that at a regional Finance Directors' Forum held last week the data for Month 2 was shared. The Director of Finance commented that a comparison with other Trusts is difficult, however, what we do know is that our Month 1 top up funding has been supported and that an audit will be undertaken by NHSI in the fullness of time. It was also noted that we are relatively comfortable with our figures and that we have the right governance in place.

It was agreed that Finance Risks will continue to be kept under review but will not be discussed as part of the meeting today.

The Governor representative, Sian Grbin, asked what our working relationship with other trusts had been like during COVID. From a finance perspective, it was noted that there had been a good level of co-operation throughout West Yorkshire and that there is an opportunity as part of our BBTU principles to keep some of those streamlined procedures. However, from a Performance perspective it was noted that working within WYAAT became more insular, this had led to conversations which are taking place around some services we accessed from other organisations which could be taken away from us.

The Committee **NOTED** the Month 2 Finance Report.

081/20 FUTURE FINANCIAL MODELLING

The Deputy Director of Finance took the Committee through a presentation which had been included within the papers. An overview described that 3 submissions had been required by the Integrated Care System (ICS) covering our activity position, associated revenue and our capital requirements.

The slides and the assumptions for each financial model were described in detail. In summary it was noted that:-

- Initial submissions had been made to ICS
- Operational and financial plans will continue to evolve
- Potential to be given a total financial envelope to work within
- National planning guidance and clarity on capital funding availability awaited
- Further national planning submissions deadline expected end July

It was recognised that there had been a vast amount of work undertaken to complete the submissions at pace and we await further national guidance.

The Committee **NOTED** the contents of the Finance Modelling presentation.

082/20 INTEGRATED PERFORMANCE REVIEW – MAY 2020

The Chief Operating Officer reported the key headlines for May. It was reported that generally we have seen a positive position. It was noted that following approval at Board we are treating patients based on 'clinical need' rather than time waited and, therefore, some KPIs will change in terms of that delivery over the next few months.

- **Emergency Care Standard** – good performance which needs to be secured due to our inability to social distance within waiting rooms in EDs where space is limited. The challenge at both sites is the provision of side rooms this will be a particular challenge with the on-set of winter.

- **Cancer** – rapid progress has been made regarding diagnostics and treatment for patients, this includes using the independent sector.
- **2 Week Waits** - not quite back at pre-COVID levels. There is anxiety that due to the large number of diagnostics being undertaken, particularly around endoscopy, that this could lead to an increase in a greater conversion rate for surgery, however, this is being tracked.
- **Stroke** – we have managed well through COVID and there is a focus with the team to ensure there is no slippage.
- **Complaints** – as part of COVID there was an opportunity for organisations to pause complaints, however, we did not take that decision and we continued to respond. We have seen an increase particularly relating to potential incidents of serious harm due to delays and conversations are taking place regarding capacity.
- **Never Event** – we have had a total of 2 'never events' since May which is a challenge.
- **Diagnostics 6 Week Waits** – following COVID, this will take a long time to recover and we are looking at about 50% to 60% of previous diagnostic capacity.
- **RTT** – outside of what has already been discussed we have 76 patients who have waited over 52 weeks. There are no plans to treat these patients as per the decision to treat on a 'clinical need' basis, however, there is a priority to undertake a clinical review to ensure that patients are not coming to any harm.

In terms of the work around stabilisation and re-set there will be clear review of capacity and the Chief Operating Officer asked for an 'external lens' from the Finance & Performance Committee when the paper comes to this forum.

It was noted that as part of COVID we had to complete a new daily report which had 10 criteria why the patient should require a bed. This meant that every patient had to be assessed every day to see if they met any 1 of the 10 criteria. This has proved to be an invaluable piece of work and is something which will continue to form part of our transfer of care.

The Committee **NOTED** the Integrated Performance Report for May.

083/20 TERMS OF REFERENCE – VERSION 5.1

The Chair presented the revised Terms of Reference (Version 5.1). The Company Secretary asked for a further amendment to Section 4.2, last bullet point to include "strategic risks", which will be captured in this version of the Terms of Reference.

The Committee **APPROVED** the Terms of Reference (Version 5.1) to be ratified at Board in September.

084/20 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were **RECEIVED** and **NOTED**:

- Draft Capital Management Group held 15 June 2020
- Draft THIS Executive Board held 27 May 2020
- Draft Commercial Investment & Strategy Committee held 21 May 2020

It was requested that a summary of any points requiring escalation to this Committee should be included with the Minutes from the individual sub-Committees.

085/20 WORK PLAN 2020/21

The Work Plan had been reviewed since the last meeting with no major changes. It was noted that COVID-19 and Business Better Than Usual (BBTU) plans had been added to the schedule. It was also noted that "Deep-Dives" will be built in to the Workplan and suggestions for topics were requested from the Committee.

086/20 REVIEW OF MEETING

It was commented that it had been a good meeting which allowed colleagues to share the work which is being carried out.

087/20 ANY OTHER BUSINESS

Project Echo – The Associate Director of Finance updated the Committee with the latest position regarding Project Echo. It was noted that regarding the 'approval' element the Health Minister has approved the transaction from his perspective and this has now been presented to the Treasury Minister for a second review. In terms of the 'general project', conversations are on hold until approvals have been received. In terms of the 'accounting' process, as previously reported, due to COVID the new IFRS 16 accounting standard has been deferred and we continue to try to find a solution to this issue with the NHSI regional team. The scale of the issue is a potential adverse revenue impact this year of £23.4m.

It was noted that internally, the Board delegated the approval level, however, as this was some time ago, the lenders are requesting further Board approval. The proposal would be to present to the Board at the end of August / early September for ratification.

It was asked if we had assured ourselves that the organisations we are dealing with are financially stable and do not pose a risk. It was confirmed that we have carried out all the relevant due diligence and we will continue to keep monitoring providers.

DATE AND TIME OF NEXT MEETING:
MONDAY 3 August 2020, 11am – 1pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on
Monday 3 August 2020, 11.00am – 12.30pm
Via Microsoft Teams

PRESENT

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

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
Rosemary Hoggart	Deputy Governor
Stuart Baron	Associate Director of Finance

ITEM

088/20 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

089/20 MEETING GROUND RULES

The Chair introduced a paper for information which outlined meeting etiquette required both in preparation for and during meetings.

The paper and contents were **NOTED** by the Committee.

090/20 APOLOGIES FOR ABSENCE

Apologies were received and noted for Gary Boothby, Helen Barker and Sian Grbin

091/20 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

092/20 MINUTES OF THE MEETING HELD 29 JUNE 2020

The Minutes of the meeting held 29 June 2020 were approved as an accurate record.

093/20 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed and noted.

088/19: Delivery of the Referral To Treatment (RTT) Standard – This item was discussed in the Private Session of the meeting.

FINANCE & PERFORMANCE

094/20 MONTH 3 FINANCE REPORT

The Deputy Director of Finance reported a break-even position at Month 3 assuming the central retrospective top-up funding of £7.91m. It was noted that year to date the Trust has incurred £9.97m worth of costs in relation to COVID, of which £2.76m relates to gowns which were purchased by the Trust on behalf of the region. The underlying position excluding COVID costs is a year to date favourable variance of

£2.06m, driven by the impact of lower levels of other activity, non-pay costs and staffing vacancies.

It was also noted that the current financial regime will continue into September, which will mean that we have been working under these rules for the first 6 months of this financial year.

The following headlines were also noted:

Capital – Year to date we are under-spent however; it was noted that capital is moving at pace in relation to our plan. At Month 3 we were reporting against a plan of circa £16m, since this point it has been confirmed that we have been allocated £4.6m for critical infrastructure funding. In addition, we are still working with the ICS to bid for further capital funding particularly to support COVID and re-set. The capital plan has been updated to reflect the £4.6m, however, other elements have still to be progressed.

Cash – The higher than planned cash position reflects the fact that we are receiving payments in advance from Commissioners to enable us to respond quickly for all our COVID requirements with suppliers, it also includes receipt of the 2019/20 Financial Recovery Funding bonus. However, Aged debt continues to be a focus and it was reported that the latest position for aged debt was slightly below £4.0m.

Forecast – There has been presentations of our Forecast to the Committee over the last few months, however, a further central submission of our forecast with a deadline of end of September has been requested. A draft Forecast position will be presented to the next F&P Committee on the 1st September 2020 prior to submission.

The Chief Executive asked for clarification of the underlying run-rate of financial performance and the Deputy Director of Finance referred to the figures previously reported regarding top-up funding and COVID costs.

In terms of creditor payments, it was noted that there is a Trust focus regarding the importance of receipting invoices in a timely manner, and in addition to the reminders which have been included in the daily Trust COVID Briefing, a 'cartoon' using the same format as The Cupboard, has been commissioned showing the end-to-end 'procurement to pay' process. In addition, as part of the online Leadership Development Modules, there is a Managing Our Money module plus additional detailed information which will be linked together.

ACTION: The draft Forecast to be presented at the next F&P Committee – **KA, 1/9/20**

The Committee **NOTED** the Month 3 Finance Report and that the current financial regime will stay in place until the end of September.

A discussion took place regarding the re-introduction of car parking charges. It was noted that we are awaiting national directive. However, there are no immediate plans to re-introduce car parking charges at CHFT and a decision had been made at Weekly Executive Board (WEB) to continue with free car parking for staff at CRH and HRI for the foreseeable future. It was suggested that a Trust-wide communication to

this effect would alleviate anxiety for colleagues and it was agreed that this will be progressed.

095/20 FINANCE & PERFORMANCE BAF RISK ALLOCATION

The Company Secretary briefed the Committee that building on the Governance Better Than Usual strategy, the Board was looking to all Board Committee members for assurance that they understand the detail and management of the risks allocated to their Committee.

It was confirmed that the BAF risks which have been allocated to Finance & Performance were as follows: -

1. Long-Term Financial Sustainability
2. Long-Term Capital Funding
3. Commercial Growth to maximise contribution to CHFT
4. Achievement of local/national performance targets

Discussions took place regarding the suggest reporting method and it was agreed that a separate page, to include the longer-term BAF risks, will be included within the Finance Report for this Committee. The Company Secretary stressed that the full detail of the risk, not just the headline, should be built into the schedule to enable the Committee to question any gaps and any assurances missed.

ACTION: To develop an additional page for the F&P Committee BAF Risk Allocation within the Monthly Report taking the comments of the Company Secretary on board – **KA, 1/9/20**

096/20 FUTURE FOCUSSED FINANCE (FFF) ACCREDITATION

The Deputy Director of Finance explained to the Committee that FFF is a national programme designed to engage everyone in improving NHS Finance to support the delivery of quality services for patients. It aims to bring finance staff at all levels of the profession together and make sure that everyone has access to skills, knowledge, methods and opportunities to influence the decisions affecting our services. The ethos is that by working together in this way we can harness our diverse and talented NHS finance workforce to produce high quality services and reduce waste in NHS spending.

It was noted that there are three levels of accreditation and that Level 1 is achieved by a process of self-assessment which the Trust's Finance department have carried out and this will be submitted in advance of the next deadline for accreditation at the end of August. Accreditation for Levels 2 and 3 follow an external inspection process, participation in this scheme is actively encouraged by NHSI / E and this will be our next step.

ACTION: To schedule on the Workplan a review of the evidence to support the application for Level 2 Accreditation – **April 2021**

The Committee **NOTED** the submission of the Trust's self-declaration of FFF Accreditation Level 1.

097/20 INTEGRATED PERFORMANCE REVIEW – JUNE 2020

The Assistant Director of Performance reported that the Trust's performance for June was 65.1%, down from the previous month. It was noted that there had been a never

event, a full investigation will be carried out and completed by the 22/9/20. A number of indicators continue to be adversely affected by the COVID situation including Sickness, Diagnostics 6 week waits, ASIs and 52 week waits. It was also noted that the SAFE domain became the first area to register a RED RAG rating in over 12 months with the accumulation of a number of targets missed including the never event.

From a positive point of view, it was noted that the Emergency Care 4-hour standard was achieved for the whole of June and just missed for type 1 only.

It was highlighted that Antibody testing figures have been added to the COVID Metrics and that further Quality outcome-based indicators are being considered as current metrics are removed from the IPR.

With regard to Complaints, the Chief Executive suggested that the Trust should have the capacity to help drive through investigations and asked that 'Complaints' be an item for the Outer Core Group agenda. It was suggested that potentially, there is a group of patients who have been waiting for treatment which had been delayed due to the prioritisation of COVID, who potentially could start to ask questions regarding their appointment. It was acknowledged that Complaints is a topic primarily for Quality Committee, but that Finance & Performance should also keep it under review to ensure we are responding in a timely manner.

ACTION: To include 'Complaints' as an agenda item for the Outer Core Group – **AB**

ACTION: To continue to monitor Complaints via Finance & Performance – in the short term, it was acknowledged the numbers may increase, and we need to ensure we are responding in a timely manner – **HB/PK, 1/9/20**

In terms of the Caring Domain and the Family & Friends testing, as previously reported, the process was going to be changed from April, but we are still waiting to hear when it will be re-introduced.

The Committee **NOTED** the Integrated Performance Report for June and the inclusion of the COVID statistics.

It was noted that correspondence received from NHSE dated 31/7/20 set out some aggressive targets for Re-set/Recovery which will be monitored through this Committee. The Chief Executive highlighted the role for both the Board and the Finance & Performance Committee to scrutinise through a Trust system lens how we can meet the aspirations of the national view.

ACTION: To review the initial top-line response to the correspondence from the centre – **HB, 1/9/20 (timing of action tbc)**

098/20 ECHO RE-FINANCING UPDATE

The Associate Director of Finance referenced the presentation which was included within the papers giving the following overview: -

- Following approval by Trust Board of the Calderdale PFI Restructuring Business Case on 5th September 2019, the Trust has continued to advance

discussions with the SPV regarding the technical, legal and financial aspects of the transaction. An update on the project was presented to Board in December 2019.

- The current expectation was for the transaction to reach Financial Close in Q2 2020, subject to timely approval of the transaction from DHSC/Treasury, however, this will be challenging unless Treasury approval is received imminently.
- Following DHSC/Treasury the Trust will commit to progression of the project and will commit to significant financial costs to complete the transaction. These will only become payable by the Trust should the transaction not complete (they will otherwise be deducted from gains realised).

The paper provided a re-fresh to the Committee of the following key elements: -

- The current transaction and the restructuring gain
- The technical and legal position
- The accounting impact

It was highlighted to the Committee that the deferral of the new accounting standard due to COVID has had an adverse impact on the Trust's in year financial performance of circa £23m. The impact of this is being discussed with NHSE/I Regional Finance Team.

Further clarification was given regarding the approval process and it was noted that there is no indication that the restructuring will not be approved. It was also noted that an Extraordinary Trust Board will be required to approve the transaction and documentation.

The Chair acknowledged the complicated process however, the Committee should be assured that he has reviewed the accounting implications with the Associate Director of Finance and that they are based on advice received from accountants PWC and our auditors, KPMG.

The Committee **NOTED** the presentation and that the timescale for completion is still uncertain.

099/20 DRAFT MINUTES FROM SUB-COMMITTEES

The following Minutes were **RECEIVED** and **NOTED**:

- Draft Minutes from the Capital Management Group held 14 July 2020
- Draft Minutes from the Huddersfield Pharmacy Specials (HPS) Board held 20 July 2020
- Draft Minutes from the CHFT/CHS Joint Liaison Committee held 25 June 2020
- Draft Minutes from the CHFT/SPC Quarterly Meeting held 10 June 2020

The Committee were reminded that a summary of any points requiring escalation from the individual sub-Committees would be provided with future sub-Committee minutes.

100/20 WORK PLAN 2020/21

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

101/20 REVIEW OF MEETING AND POINTS TO ESCALATE TO THE BOARD

It was noted it had been a good meeting and the following points should be escalated to Board: -

- Month 3 position with the overall break-even/COVID top-up payments as in previous months.
- Financial regime to stay in place until at least the end of September
- Requirement for a re-forecast for the end of the year, a draft will be reviewed at the next F&P prior to submission at the end of September.
- F&P BAF Risk Allocation – reporting and review process agreed.
- Future Focussed Finance Accreditation – application for Level 1 status to be submitted with the ambition to apply for Level 2 & 3.
- IPR – reduction in performance in June with the Safe domain reporting RED for the first time in 12 months, however, A&E performance was still strong. Work continues to revise the IPR and the indicators which will be discussed at the next F&P Committee.
- Project Echo Update – awaiting Treasury approval with the hope that this will conclude within the next Quarter.

102/20 ANY OTHER BUSINESS

No other items raised.

DATE AND TIME OF NEXT MEETING:
TUESDAY 1 September 2020, 11am – 1pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 22 July 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
Kirsty Archer	Deputy Director of Finance
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Kim Betts	Internal Audit Manager, Audit Yorkshire
Salma Younis	Senior Manager, KPMG
Steve Moss (Item 56/20)	Head of Anti-Crime Services, Audit Yorkshire
Jackie Ryden	Corporate Governance Manager (minutes)
Maxine Travis	Senior Risk Manager
Rob Birkett	Director of Digital Services, The Health Informatics Service
Suzanne Dunkley (Item 51/20)	Director of Workforce & Organisational Development
Alison Wilson (Item 51/20)	Contracts Compliance Manager

47/20 APOLOGIES FOR ABSENCE

Apologies were received from Gary Boothby, Mandy Griffin, Olivia Townsend and Clare Partridge.

The Chair welcomed everyone to the Audit and Risk Committee meeting. Rob Birkett was attending on behalf of Mandy Griffin, Maxine Travis, Senior Risk Manager attending for the first time in line with revised terms of reference, Steve Moss on behalf of Olivia Townsend, Counter Fraud, and Suzanne Dunkley and Alison Wilson to present the deep dive on Health and Safety.

48/20 DECLARATIONS OF INTEREST

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

49/20 MINUTES OF THE MEETING HELD ON 16 JUNE 2020

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

Year End Audit Report – ISA 260
The External Audit Partner KPMG explained the findings related to the significant risks. There was one unadjusted audit difference related to EPR carried forward and two control recommendations related to the theatre stocktake and payroll reconciliations

Annual Report and Accounts
The following sentence will be added at the beginning of the agenda item 43/20:

At their meeting on 7 May 2020, the Trust Board delegated authority to the Audit and Risk Committee to sign off the annual accounts and annual report. This proposal was supported by the Audit and Risk Committee at the meeting on 7 April 2020.

Going Concern Report
CP pointed out that last year a ~~disclaimer~~ material uncertainty had been included in the report due to the amount of debt, but circumstances have changed and assurance has been received for financial support from NHS Improvement (NHSI) which has led to many Trusts receiving clean

opinions.

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

50/20 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updated accordingly.

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

51/20 HEALTH AND SAFETY DEEP DIVE

The Director of Workforce & Organisational Development and the Contracts Compliance Manager provided a presentation on the health and safety arrangements within CHFT. The presentation included details of the Health and Safety Committee, the governance framework for both HRI and CRH, progress on the action plan and the next steps for outstanding actions. Key points to note were as follows:

- The Health and Safety Committee receives feedback and has representation from specialist advisors, divisions, Calderdale and Huddersfield solutions Limited (CHS), ISS and Engie, which allows for shared learning.
- The monthly CHFT/CHS Contracts and Performance meetings discuss, investigate and challenge risks, escalating where necessary.
- CHS have their own Health and Safety Committee which meets monthly to discuss, manage and monitor incidents.
- There is a good working relationship between CHS the Private Finance Initiative (PFI), ISS and Engie.
- Suzanne Dunkley and Karen Heaton act as Board champions for health and safety to provide an extra layer of assurance.
- Action plans were presented to the Trust Board in January 2020 and a number of these are still in progress. Work with the interim Head of Health and Safety is ongoing to progress outstanding items.
- Interviews are scheduled on 5 August 2020 to appoint a Head of Health and Safety. Five excellent candidates have been shortlisted.
- An audit on health and safety is currently being undertaken and all actions resulting from this will be added to the overall action plan.

RH asked for clarification regarding the CHFT/PFI Strategic Meeting reporting into the Finance & Performance Committee. The Contracts Compliance Manager explained that previously this meeting had been less formal but the meetings have now been formalised and scheduled for 2020 and will report into the Finance & Performance Committee via the Director of Finance using the minutes and key points. Terms of Reference are currently being finalised and will be presented to the Finance & Performance Committee.

A discussion took place on the importance of escalating key points to Board committees and it was agreed that a summary page to accompany meeting minutes was the most effective method of addressing this, as previously agreed at the Audit and Risk meeting in January 2020. A template was approved and previously circulated. The Director of Workforce & Organisational Development confirmed this will be provided for future meetings.

OUTCOME: The Committee **NOTED** the details provided in the Health and Safety Deep Dive presentation.

52/20 AUDIT AND RISK COMMITTEE ANNUAL REPORT 2019/20

The Audit and Risk Committee Annual Report for 2019/20 was received. The report detailed the role of the Audit and Risk Committee including membership and attendance and described the activities of the Audit and Risk Committee during the year in line with the duties within the terms of reference.

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee annual Report for 2019/2020 and **NOTED** the assurances that the Audit and Risk Committee met its duties for 2019/20.

53/20 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 June 2020. She brought to the Committee's attention the heightened risk this year of potential losses and special payments relating to Covid-19. Specific drugs were both purchased by the Trust and manufactured by Hospital Pharmacy Services for use specifically in relation to Covid-19. If these are not used, future losses may need to be re-categorised. Should this be the case, as these costs relate to Covid-19 they would be funded retrospectively by means of an application by the Trust for 'top up' funds**.**

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 waiting of standing orders to enable volume and value to be monitored during the first financial quarter of 2020/21. The Deputy Director of Finance explained that due to the date of the previous meeting and submission of papers prior to the month end the report shows waivers completed from 27 March 2020 until the end of quarter one.

In April 2020 a paper was approved by the Audit and Risk Committee to allow for special measures that would have to be in place through the Covid-19 emergency period. It was noted in the paper, with regard to tenders, that the nature of the Covid-19 preparations and fast pace required to deal with the limitations of supply of key products were likely to lead to a higher than usual number of exceptions.

To ensure full transparency, the details of the orders placed through Procurement specifically for Covid-19 were provided as appendix 4 to the report. The Deputy Director of Finance reported that the Trust is currently considering whether to issue a Transparency Notice for these single source items, which could take the form of publication on the internet.

RH asked it this would require consultation with the regulators, and the Deputy Director of Finance replied that this would not be necessary although advice could be taken from the Procurement regulatory body.

The Chair asked if there will now be opportunities to drive greater value for money in future and the Deputy Director of Finance advised that now the urgency of the situation has somewhat abated and the supply of Personal Protective Equipment has improved, there will be opportunities to return to previous practices.

The Chair queried a number of items in the Families and Support Services (FSS) Division and the Health Informatics Service. The Director of Digital Services explained that this related to a legacy

system and once the system is decommissioned this will no longer be required. The Deputy Director of Finance agreed to provide more details for the FSS items.
Action: Deputy Director of Finance to provide further detail for FSS waivers.

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

54/20 INTERNAL AUDIT

Internal Audit Quarter 1 Follow Up Report and Internal Audit Progress Report

The Internal Audit Manager advised that fewer internal audit recommendations have been implemented during quarter one than usual, consistent with other organisations, due to the availability of staff during the pandemic. It is expected that this will increase during the second quarter.

A number of major recommendations are still outstanding, one of which is overdue. This relates to cybersecurity. There is a big piece of work to be completed and a request has been made to extend the date to January 2021. This will be closely monitored.

The Chair asked what actions are being taken in the interim and what is the risk exposure to the Trust. The Director of Digital Services advised that this is related to a number of different systems to manage asset management of computers rather than any cyber security issue. It is closely linked to the data security and protection toolkit and there is an action plan in place to bring this back in line, hopefully by September 2020 or at the very least for the March submission in 2021.

The Chair raised a query regarding the percentages provided for progress on the recommendations and asked for clarification.
Action: Internal Audit Manager to check the percentages for progress on recommendations and provide clarification.

Eight reports have been issued since the last Audit and Risk Committee meeting in April 2020. All reports with a high or significant opinion are available in the Review Room and were circulated with the agenda and meeting papers, apart from the audit report for Medical Devices. This has not been provided as the Calderdale and Huddersfield Solutions Board wish to review this prior to its presentation at Audit and Risk Committee. The Internal Audit Manager will ensure that in future it is timed to avoid the Audit and Risk Committee waiting to see the report.

A number of requests have been made to Audit Yorkshire for changes to the audit plan which needs to be flexible for this year. Some of the requests are related to Covid-19, which is a separate agenda item. There has also been a request to review charitable donations. The plan has to be flexible but will need to mirror the Trust's current risks. The Internal Audit Manager will meet with the Company Secretary and Senior Risk Manager to ensure these are aligned. A new plan will be presented at the Audit and Risk Committee meeting in October 2020.
Action: Internal Audit Manager to present the revised audit plan to the Audit and Risk Committee Meeting in October 2020.

DS asked about the recommendation from December 2018 regarding the consultant job plans and the timescale for this recommendation. The Internal Audit Manager will investigate and respond to DS outside of the meeting.
Action: Internal Audit Manager to provide DS with the timescale for the consultant job plans.

Internal Audit Report CHFT Car Parking Strategy and Controls
The Internal Audit report for Car Parking Strategy and Controls was provided. This has a limited assurance opinion and has a significant number of recommendations. The Internal Audit Manager explained that these primarily stem from the lack of a strategy or policy for Car Parking being in

place. These are on hold as the Trust awaits guidance in respect of how it should implement the Government's commitment to provide free hospital car parking for those in the greatest need.

RH asked if the targets for addressing the car parking issues are realistic and the Internal Audit Manager advised that she will be reviewing this with the Managing Director of Calderdale and Huddersfield Solutions Limited to check that the timing is correct and achievable. The Chair added that reconfiguration plans could also affect the strategy. RH pointed out that car parking is a sensitive issue with staff and this needs to be taken into consideration.

OUTCOME: The Committee **APROVED** the Internal Audit Quarter 1 Follow Up Report and the Internal Audit Progress Report.

55/20 INTERNAL AUDIT COVID-19 GOVERNANCE

A request was made for Internal Audit to assist the Trust in its completion of Audit Yorkshire's Response to Covid-19 - Governance Arrangements & Checklist document. A high-level review was also undertaken with a view to providing independent assurance over the changes made by the Trust through verification of evidence/documents provided by the Trust.

The review found that that the Trust made adequate and appropriate amendments to its governance arrangements in response to the Covid-19 pandemic, and no cause for concern was found by Audit Yorkshire.

OUTCOME: The Committee NOTED the outcome of the high-level review on the changes made to the governance arrangements in response to Covid-19.

56/20 LOCAL COUNTER FRAUD

1. Local Counter Fraud Progress Report

Steve Moss, the Head of Anti-Crime Services, Audit Yorkshire, presented the Counter Fraud Progress Report. He apologised for the late submission of the papers and advised that Olivia Townsend has taken over the role as Lead Local Counter Fraud Specialist (LCFS) following the retirement of Adele Jowett.

The Head of Anti-Crime gave an update on key findings from the work undertaken for the last reporting period and highlighted key points. A staff awareness survey has recently been circulated to a number of teams and 70 responses were received. A detailed summary of the results will be presented to the Audit and Risk Committee meeting in October 2020. The Anti-Crime Service has continued to disseminate information throughout the pandemic using a variety of methods, including Covid-19 Fraud Alert newsletters. The LCFS has met with the Trust's Fundraising Manager to discuss the potential of fraud within the Trust's Charitable fund and has offered to review the new policy and procedure documents prior to their implementation to ensure they are robust in the prevention of fraud, bribery and corruption.

Since the last Audit and Risk Committee meeting, the LCFS has undertaken one formal investigation related to the booking of accommodation. Prompt action was taken and there was no financial loss to the Trust. A report has been submitted to the Health and Care Professions Council which will conduct their own investigation which is likely to take around six months. The outcome of the report will be presented to the Audit and Risk Committee when it becomes available.

The Head of Anti-Crime advised that information has been received from the NHS Counter Fraud Authority (NHSCFA) including details of their strategic intelligence assessment and the annual review of potential fraud issues. This highlights a number of areas of emerging threats or losses in the NHS. Most of the issues identified have been picked up in the 2020/21 counter fraud plan and have actions to review and address them.

The Counter Fraud Authority Standards will be changing from 2021. There is a lack of clarity over the implications of these changes and a working group has been set up to address this. Steve Moss will be a member of the group.

The NHSCFA has developed a project aimed at ensuring every health body has a nominated counter fraud champion; Andrea McCourt has volunteered to undertake this role on behalf of the Trust, and will meet with Olivia Townsend to talk through any issues relating to the role of the champion.

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

2. Local Counter Fraud Annual Report

The Head of Anti-Crime presented the Annual Counter Fraud Report for 2019/2020 summarising the work undertaken in 2019/20 under the four areas of strategic governance; inform and involve; prevent and deter and hold to account.

In order for NHSCFA to derive a clear picture of the work conducted and assess compliance with the counter fraud standards, every NHS provider is required to submit a Self-Review Tool (SRT). The SRT is intended to enable the organisation to produce a summary of the anti-fraud, bribery and corruption work it conducted over the previous financial year. Organisations are required to complete the SRT annually and return it with the Local Counter Fraud annual report to NHSCFA. The Trust's SRT for 2019/20 was approved by the Director of Finance and Audit and Risk Committee Chair and submitted prior to the deadline of 30 May 2020. The report identified that the Trust has fully met 21 of the standards and two of the standards were recorded as neutral, which has given the Trust an overall status of green. This evidences the positive work that has been undertaken by the Trust to support the anti-fraud role. Two areas were rated as neutral as there were no witness statements or interview under cautions undertaken in year. The NHSCFA's Quality and Compliance Team select a number of organisations to be assessed along with the type of assessment to be undertaken but CHFT has not been selected in the past.

Following a query from RH, the Head of Anti-Crime gave details of Olivia's background and advised that Olivia has been working in the Trust for a number of years and has a wealth of experience and the support of a good team.

OUTCOME: The Committee **APPROVED** the Local Counter Fraud Annual Report for 2019/2020.

57/20 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 Senior Manager KPMG advised that KPMG has set up a dedicated website to advise on the response to Covid-19 which includes a number of useful documents.

The accounting manual for 2020/2021 has been issued. There are no significant changes. A new Code of Audit Practice came into force on 1 April 2020. The most significant changes to the new Code are in relation to auditors' work on value for money arrangements. A consultation to seek views on the guidance to support auditors' work on value for money arrangements is ongoing and the Trust has an opportunity to comment on this. Also ongoing is a consultation on the exposure draft for the 2020 version of Practice Note 10: 10 Audit of Financial Statements and Regularity of Public Sector Bodies in the UK.

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

58/20 REVIEW OF BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the first review of the Board Assurance Framework (BAF) for 2020/2021 for approval prior to review at the Trust Board on 3 September 2020. The updated BAF is the first for the new financial year 2020/21 and reflects the sign-off of the strategic objectives by the Board on 2 July 2020 and the impact of Covid-19. Six new risks have been added, three with risk scores rated as red and three rated as amber:

- 1/20 Delivery of Trust Clinical Strategy - red
- 2/0 Investment to fund Digital Strategy – amber
- 3/20 Business Better than Usual service transformation – amber
- 4/20 CQC rating – amber
- 5/20 Service capacity due to Covid-19 response – red
- 6/20 Climate action failure – red.

All risks have also been updated and it is proposed to remove one risk, 5/19, relating to EPR benefits realisation as the risk target score of 10 has now been met with the approval of the Digital Strategy.

The Company Secretary explained that following discussions at Private Board, the Board wish to focus more on risk exposure and trend reporting. The paper identified the risks by risk appetite category and by risk exposure.

The Company Secretary reported that in order to ensure a more strategic discussion on risk at the Board and its Committees, it is proposed to streamline the review of risks. The Board will continue to review the BAF three times a year at its meetings in March, September and November, with oversight and review by the Audit and Risk Committee prior to this in January, July and October. The high-level risk register is currently presented at each meeting of the Board.

It is proposed that each Board Committee has a greater role in reviewing the risks on the BAF and any operational / high level risks that are aligned to these risks. The high-level risk register would then be presented to the Board three times a year, with focused discussion on key areas, with greater assurance from Board Committees that they have reviewed in detail both operational and strategic risks relevant to the work of the Committee. This will enable the Board to focus discussion on high level risks of concern rather than reviewing all risks.

Early discussions with the Non-Executive Directors who chair Board Committees and the Director of Nursing as the lead Director for risk management are supportive of this approach, which moves forward the direction of travel agreed at the Board on 2 July 2020.

Board Committee Chairs will be requested to schedule deep dive reviews of the risks in their workplans during the year. This will move ownership to the whole committee and ensure shared ownership and understanding of the actions required to mitigate the risks.

It is anticipated that a risk will be added relating to health inequalities once national guidance on this is received. This is expected to be received during August.

RH advised that the risk relating to long-term financial sustainability, reference 18/19 should be rated at 16 as this was revised downwards by the Finance & Performance Committee. The Deputy Director of Finance agreed to confirm this with the Director of Finance.
Action: The Deputy Director of Finance to check the score for risk 18/19 with the Director of Finance.

RH confirmed his agreement for the Finance and Performance Committee review of risks 8/19 and 14/19 but commented that he was not certain that Finance & Performance Committee looks at the BAF risk in relation to capital funding.

RH raised a number of queries relating to the proposed allocation of the 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. The Company Secretary pointed out that the digital strategy risk relates to securing appropriate investment. The Chair suggested that the list of allocations is discussed and agreed at the weekly Non-Executive Directors meeting on 29 July 2020.
Action: Company Secretary to provide paper for Non-Executive Directors meeting on 29 July 2020 to be presented by the Chair of Audit & Risk Committee.

The Senior Risk Manager commented that more work is required to ensure that the risks on the high-level risk register are aligned with the BAF.
Action: Company Secretary to meet with Senior Risk Manager to ensure that the risks are aligned between the Board Assurance Framework and the High-Level Risk Register.

The Chair thanked the Company Secretary for the detailed paper and welcomed the focus on risk exposure. He commented that the information provided in the updates was thorough but requested that any areas with a gap in controls or assurance should include an action and timelines to address these.

OUTCOME:
The Committee **AGREED** the addition of 6 new risks to the Board Assurance Framework, **AGREED** the removal of risk 5/19 EPR benefits realisation, **NOTED** the updates to risk and movement in risks scores for risks 4/19, 8/19, 9/19 subject to clarification of the risk score for 18/19, **NOTED** the risk exposure identified in the paper, **AGREED** that Board Committees schedule routine review of BAF risks and **NOTED** that a new risk on health inequalities may be added to the BAF.

59/20 COMPANY SECRETARY'S BUSINESS

1. Audit and Risk Committee Workplan

The annual workplan for the Audit and Risk Committee was circulated for consideration.

The Company Secretary advised that a number of items have been added to the workplan, including clinical audit as the recent Committee Self-assessment identified a gap.

RH referred to a document issued by the Good Governance Institute and asked if the risks related to the Integrated Care Systems (ICS) were covered in the workplan. The Chair advised this was not explicitly addressed in the workplan. Following a discussion on the risks that an organisation would have in relation to the ICS and their potential impact on the Trust, the Company Secretary agreed that this is an area for development and will consider how this can be achieved and asked if auditors had any insights on this from other Trusts.

The Head of Internal Audit advised that there is national recognition that there is no clarity in terms of the assurance links between organisations and the ICS. This has been also recognised by the Healthcare Financial Management Association (HFMA) Governance and Audit Committee and two of the members have agreed to take on a project to work with the HFMA and NHSE/I to review how local assurance could work given that assurance currently is through partnership groups and is informal. There is a requirement for a more formal governance structure. Audit Yorkshire are undertaking some work with organisations and CCGs on this, but this needs a major drive to get

clarity and lines of accountability and reporting lines in place. This has been considered as part of the Audit Committee events and Audit Yorkshire are planning to cover this next year when it is hoped there will be more clarity in terms of legislation.

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee 2020/21 Workplan.

2. Review of Audit and Risk Terms of Reference and Job Description of Audit Chair (Approve)

The Audit and Risk Terms of Reference and Job Description of the Audit Chair were presented for review and comment. These had been reviewed by the Chair and Company Secretary and the changes noted in the papers.

OUTCOME: The Committee **APPROVED** the Audit and Risk Terms of Reference and the Job Description of the Audit Chair.

3. Proposal of Future Audit and Risk Committee Meeting Dates 2021 (Approve)

The proposal for future dates of the Audit and Risk Committee meetings was provided for 2021. The Committee meetings will take place quarterly. An Extra-ordinary Committee meeting will be arranged in May 2021 to sign off the annual report and accounts.

RH commented that he is not available for the meeting scheduled in April 2021 but will discuss with Jackie Ryden outside of the meeting.
Post meeting update: The Audit and Risk Committee meeting in April 2021 has been rescheduled to Monday 12 April 2021.

OUTCOME: The Committee **APPROVED** the proposal of future Committee dates, including dates for when the internal and external audit pre-meetings will take place.

4. Meeting Groundrules

The Company Secretary provided a set of meeting Groundrules which had been approved by the Board as part of the Trust's Governance Better than Usual review on 2 July 2020. These need to be operationalised by all the committees and the Company Secretary requested that Committee Chairs share these with their relevant committees.

OUTCOME: The Committee **AGREED** to **ADHERE TO AND PROMOTE** the use of the meeting groundrules to increase meeting efficiency.

5. Covid-19 Donations and End of Year Nil Declarations

The Company Secretary advised that she recently completed a piece of work with the Director of Finance and the Fundraising Manager to ensure there are clear arrangements to ensure donations given to the Trust are recorded by the Charity, with personal individual gifts to be reported as usual via the online system for declarations .

The process for recording end of year nil declarations, which was deferred from earlier in the year due to the Covid-19 pandemic, has now begun. Approximately 50% of the declarations have been submitted within the last three days. A summary report will be presented to the Audit and Risk Committee in October 2020.

OUTCOME: The Committee **NOTED** the verbal update on Covid-19 Donations and End of Year Nil Declarations.

60/20 AUDIT AND RISK SELF ASSESSMENT 2019/20 REPORT

The Company Secretary presented the collated views for the Audit and Risk Committee self-assessment undertaken in February 2020 and advised that this report had been deferred from the April agenda which had been streamlined due to the response to the Covid-19 pandemic. The report included the key points for further work during 2020/2021.

The Company Secretary proposed that the Audit and Risk Committee consider whether to invite the executive lead to future committee meetings where limited assurance reports have been issued by Internal Audit, in line with a number of other organisations. This proposal was supported by the Committee and it was agreed that this would be considered on a case by case basis.

In order to improve Committee engagement and the relationship with other Board Committees, given the over-arching role of the Audit and Risk Committee, it is planned to present annual reports from Board Committees to the Audit and Risk Committee for assurance from 2020/2021 onwards.

In order to support the streamlined governance approach and adhere to the meeting groundrules agreed at the Board on 2 July 2020 for Governance Better Than Usual, the Audit and Risk Committee has begun to action this by placing assurance information in the Review Room on Convene and focusing discussion during the meetings on items for approval.

The Chair commented that it was pleasing to note that several points identified in the self-assessment are already being actioned, in particular the need to improve the relationship with other Board Committees. RH added that this will also be enhanced by spreading responsibility of the risks in the Board Assurance Frameworks to individual Committees.

OUTCOME: The Committee **NOTED** the outcome of the Audit and Risk Committee self-effectiveness review for 2019/20 and the areas for continued improvement contained in the report.

61/20 SUMMARY REPORTS AND MINUTES TO RECEIVE

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

- Risk and Compliance Group
- Information Governance and Risk Strategy Group
- Data Quality Board

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.

The Company Secretary commented that the summary reports provided assurance that work is continuing throughout the pandemic despite the cancellations of some meetings due to the pandemic. As discussed earlier on the agenda, a summary report will be provided going forwards for the Health and Safety Committee meetings.

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

62/20 ANY OTHER BUSINESS

There was no other business.

63/20 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Board Assurance Framework – revisions to BAF and focus on driving the BAF through the sub-committees.
- Internal audit – fluid plan which will be revised.
- Internal audit reports - Good assurance received from the Covid-19 Governance audit, three reports with limited assurance (GP Communications, Car Parking, End of Life follow up)
- Annual Reports to be provided for all sub-committees.

64/20 DATE AND TIME OF THE NEXT MEETING

Wednesday 21 October 2020 10.00am – 12.00pm.

65/20 REVIEW OF MEETING

Progress is being made on reducing the volume of papers.
The deep dive on health and safety was helpful.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 29 June 2020

93/20 WELCOME AND INTRODUCTIONS

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Christopher Button **(CB)**	Lead Cancer Nurse
Andrea Dauris **(AD)**	Associate Director of Nursing, Quality and 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
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Naheed Razzaq **(NR)**	Risk Manager
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Maxine Travis **(MT)**	Senior Risk Manager
Lucy Walker **(LW)**	Quality Manager, Calderdale & Huddersfield CCG
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

94/20 APOLOGIES

Lindsay Rudge **(LR)**	Deputy Director of Nursing

95/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

96/20 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Monday, 1 June 2020 were approved as a correct record.

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

97/20 INTEGRATED PERFORMANCE REPORT

EA reported that the Integrated Performance Report at appendix B1 and B2 was discussed at length at the Finance and Performance Committee meeting earlier today, including stabilisation and reset, and the impact that this could have on care pathways. Due to this being one of the quality and safety priorities going forward, the Finance and Performance Committee and Quality Committee need to ensure that this is referenced in both groups.

It was stated that the report should remain on the agenda as the dataset continues to evolve.

98/20 MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

ES presented appendix C which provided an overview of medication safety issues reported at the Medication Safety and Compliance Group (MSCG) in the last quarter.

- Medication incidents:
  - a comparison of incidents from quarter 4 in 2018-2019 (334) and quarter 4 in 2019-2020 (242) show a reduction;
  - four of the incidents which resulted in moderate patient harm in quarter 4 2019-2020 were summarised;
  - the total number of mediation incidents reported in 2019-2020 (1227) was broken down into groups:

  - 532 (43%) related to administration errors
  - 239 (20%) related to prescribing errors
  - 207 (17%) related to pharmacy errors

- COVID-19 medication issues:
  - *medication shortages of critical medicines and renal replacement fluids* – there were national supply chain issues with medications required to treat patients requiring critical care and/or hemofiltration due to demand during the COVID-19 surge. Actions were taken to mitigate risks.
  - *Oxygen vacuum insulated evaporator (VIE) security* – alerted to increased risks of a security breach to oxygen VIE compounds during COVID-19. A task and finish group was established to review current security and identify any improvements required.
  - *Oxygen capacity* – a task and finish group worked collaboratively to produce clear guidance for interpreting oxygen capacity and therefore understanding the number of ventilators and continuous positive airway pressure (CPAP) equipment that can be in use at any one time
  - *Medical gas compliance / training* – deep dive carried out in relation to governance and additional training requirements for colleagues

- General medication safety updates
  - *Active Temperature monitoring update* – funding now approved for an active temperature monitoring system for medication fridges and for ambient temperature monitoring in medication storage areas
  - *Key security* - all the required key safes have now been installed to ensure safe storage of medication keys and spare keys for those areas not open 24/7.
  - *Controlled drug updates* – report received from internal audit undertaken in March 2020, and action plan to be reviewed by the MSCG. The audit identified several areas of significant progress, as well as some areas to improve compliance.
  - *Audits*:
    - *Medication security NHS protect audit* - audit completed and action plan to be monitored by the MSCG.
    - *Delay and omission of administration of high-risk drugs audit* – audit completed in April 2020, with recommendations being monitored by the MSCG
  - *Pharmacy system interface* – a business case for the interface has been approved. Medications are currently processed by a manual transcription by the pharmacy team, and the interface will reduce transcription errors and enhance medication safety.

Since the report was written, a more comprehensive medical gases paper has been produced and will be submitted to the Weekly Executive Board, then to this Committee. The report further describes the Health Technical Memorandum (HTM). An updated MSCG terms of reference were also submitted for ratification, with a few amendments made. These were agreed.

It was asked how CHFT benchmarks regionally or nationally against the 1227 medication incidents reported for 2019-2020. ES stated that it comes up on the Model Hospital pharmacy report, and overall, CHFT level of harm is good as in low level, with very few serious and moderate harms, however, CHFT may not be as good as reporters as other organisations. Whilst it is good news to see a reduction in medication incidents, it is healthy to have a lot of incidents in order to see where the problems are and to see a low level of harm. Historically, the four incidents are on track considering the number of drugs that are prescribed and administered daily, especially during this time period.

EA stated that the medical gases group has been an issue in the organisation for some time and would strongly support the governance of medical gases into the Quality Committee.

OUTCOME: The Quality Committee received and noted the report.

99/20 CANCER BOARD REPORT

CB presented appendix D summarising that the Cancer Board has now met eight times and chaired by Helen Barker (Chief Operating Officer). The membership includes the cancer management team of Helen Barker, Jo Dent as Lead Clinician, Maureen Overton as Lead Cancer Manager and CB. Other members include the clinical leads of the cancer multi-disciplinary teams, the divisional general managers, and representation from Radiology, Pathology, Pharmacy, Neuro-specialists and Cancer Information Specialist teams.

The last meeting took place in January 2020, and the Board has not met formally since COVID-19 but have had interim meetings to discuss the impact of COVID-19 on the cancer service, but this is not reflected in this report which is from 15 January 2020 meeting.

The meeting had a focus on performance, which is managed by Maureen Overton, who has weekly meetings with operational managers and the cancer teams, and where necessary the divisional general managers, to look at any breach avoidances.

A large part of the meeting was dedicated to the new 28-day Faster Diagnosis Standard which was due to start reporting from 1 April 2020. That has now been delayed due to COVID-19 but have been shadow monitoring for the last 12 months.

During quarter 3 (October to December 2019), five of the seven national operational cancer waiting times standards were achieved. The targets missed were described, and the Cancer Board were not sure how CHFT benchmarked against other trusts in terms of the 104-day performance breaches, therefore this has been reviewed and a report is being prepared for the next Cancer Board. One of the targets achieved; the 62-day standard, is one of the two well-published metrics in the mainstream press, and nationally, 48 trusts achieved this target. CHFT was 15th on the national league table.

The Cancer Board had an in-depth discussion on the new 28-day faster diagnosis standard, which is the time from urgent referral from GP, to a patient being informed of a cancer diagnosis. The target is now within 28 days, and each cancer site team reviewed their position with the monitoring and how they were trying to achieve the standard. From the overall shadow monitoring of the standard, CHFT are aiming for a target of 75%, and three months ahead of the official reporting, CHFT performance stood at 74.3%. The Board felt to be on course to achieving the target which was due to come into effect on 1 April 2020. There were some areas where the shadow monitoring was around 40%, and some suggestions were made and put in place following the meeting.

Also discussed were incidents, complaints and compliments:

- From April to December 2019, there were 95 incidents in total where cancer was mentioned. This included two serious incidents and both investigations were concluded, and the lessons learnt distributed not only to the teams where the incidents took place, but also to wider teams. 65 of the incidents were in the *'assessment / treatment / diagnosis'* category, and 46 of those (71%) were 104-day breaches. For the remaining cases, there were no themes.
- For the same reporting period, there were 27 complaints and concerns where cancer was mentioned. The category of cases included '*clinical treatment*', *'communication failure', 'car parking', 'privacy and dignity',* and *'inappropriate discharge'*.
- For the same reporting period, five compliments were recorded on the Datix system where cancer was mentioned, which under-represents the compliments which are received through cards, letters, etc and not formally recorded on systems.

The Cancer Board agreed to build on the work of reviewing incidents with the addition of complaints and compliments. This will enable identification of themes and disseminating lessons learnt or changes to practice.

The Board made the decision to add patient and primary care representation to future meetings, which will start with patient representation at the next meeting and primary care representation in July 2020.

The First Steps health and wellbeing programme for newly diagnosed cancer patients, aimed at providing information and education to empower people to take some ownership of their illness and its management, started as face-to-face sessions in October 2019 and has been well received by patients and their supporters. This has been moved online for the last few months due to COVID-19.

It was stated that there are more compliments which are made than compliments which are logged and is important that they are recorded for the benefit of the staff.

It was stated that looking forward, there will be some delays in cancer diagnosis, and it was asked what the approach and governance route will be for reporting the consequences. CB stated that a weekly meeting has been taking place reviewing the backlog position in each cancer speciality on what diagnostics have caused an impact on any delays and what treatment delays there have been. The biggest impact is diagnostics and a meeting where divisional representatives responsible for patients in their division are looking at patients on a case-by case basis. An example of this is where endoscopy and colonoscopy were closed for the first two months of COVID-19. The service has now re-opened and there were less than 10 two-week wait patients waiting for a date for an endoscopy or colonoscopy. Those patients had an appointment date before the end of June 2020.

It was also asked where the quality outcome measures are being reported. CB reported that due to there not being another date as yet for the next Cancer Board, the stabilisation and reset meetings for cancer are available to report and discuss these measures, which will then feed into the Incident Management Team (IMT) meeting, and any relevant issues will be reported into the Quality Committee.

EA stated that we need to ensure that the stabilisation and reset workstreams do not cut across what is already in place. EA and DB will be meeting with Helen Barker to ensure that different groups are not reporting into other groups when there is already a clear reporting structure. With regard the quality priorities, this has to be our number one priority for the next few months and need to ensure that we do not lose anything, but equally do not start duplicating work and setting a dual governance structure in place.

It was asked if there were any timescales for when the Board would like to see primary care colleagues joining the meeting. CB reported that the plan was for primary care to join in July 2020, but due to no further meetings taking place, this has not transpired. There is a proposal for the stabilisation and reset group to become the Cancer Board in the future, but the membership would need to be amended, and would be opened to primary care representation.

OUTCOME: The Quality Committee received and noted the report.

100/20 PATIENT SAFETY GROUP REPORT

MT presented appendix E highlighting a summary of work undertaken and actions from the Patient Safety Group during quarters 3 and 4 of 2019-2020, including the membership of two junior doctors who have made very valuable contributions to the Group.

Reports received from sub-groups included updates from:

- *Resuscitation Group* – the Group looked at incidents and root cause analyses around the commencement of cardiopulmonary resuscitation (CPR) and the resuscitation process. There have been a number of incidents, with an action plan put in place and learning shared from those cases. An audit was also undertaken on the paediatric resuscitation trolleys which identified improvements needed to be made.

- *Hospital Transfusion Group* – transfusion-related activity, particularly serious hazards of transfusion (SHOT) reportable incidents and the robustness of investigations to identify learning have been discussed. Risks have also been identified and placed on the risk register, with further work to be done.

- *Pressure ulcer collaborative* – since COVID-19, there has been a shift in reporting of pressure damage from inpatient into the Community, which reflects that more patients are being kept at home during the pandemic meaning that incidents are occurring in the community rather than as inpatients.

- *Medical devices and procurement Group* – reporting was based on risk register entries and some are aligned with the quality priorities in terms of medical devices and end of life support.

- *National Early Warning Score (NEWS)* – training was refreshed with a baseline of zero with an expected reduction in compliance whilst training was completed again. That has been an upward trend, however hindered by COVID-19, and will be picked up in the next quarter. Compliance is now being captured on ESR to allow for easier reporting.

- *Patient safety alerts* – The Group has oversight of the delivery of actions, and a recent meeting has taken place with the central alert system (CAS) officer to look at the process for escalation, the embedding of monitoring to strengthen relationships with safety alert leads, and to improve governance processes. This is currently work in progress ensuring that reporting into the national system is done in a timely and comprehensive manner.

- *Healthcare Safety Investigation Branch (HSIB)* – these are national investigations, and the relevance of reports are assessed and reported into the PSG on a quarterly basis, with a gap analysis on how to comply with the recommendations and what the action plans are. Each gap analysis has a named lead and are aligned with serious incident investigations within the Trust.

- *Junior doctor feedback* – reports have been received on surgical and prescribing issues, one of which was delayed removal of ureteric stents, which has recently commenced as a HSIB investigation, which will allow feedback to be linked into the national report.

In relation to the assurance of patient safety alerts, it was asked who signs the required actions off as being taken. It was stated that this is currently being reviewed and working through the Central Alert System policy to ensure that the governance aspect is clearly documented, as there have been some changes to alerts and incidences where it is not clear who is closing actions, and in conjunction with the risk team, are recording actions more robustly on the Datix system. This is all part of the work currently in progress.

In relation to the Hospital Transfusion update, it is pleasing that a new Chair has been appointed, and that the risk register has been reviewed, and looked at the quality improvement work. It was stated that those priorities are now better triangulated and aligned and now need to take forward work with divisions to ensure that when SHOT incidents are reported, that it is not the Transfusion team's responsibility to undertake the root cause analysis, as it should sit within the division that the incident occurred in order for the learning to be embedded in that division. The Chair stated that it would be good to have at a future date, a report to this Committee on the development work undertaking and how that is progressing. In terms of the audits not yet completed, it was noted that there was a national clinical audit that could not be supported from the medical division. It was asked how that would be addressed. It was stated that this is being taken back into the Hospital Transfusion Committee to review their audit programme and to prioritise that in the context of the wider trust priorities. It is unsure of the delivery of the audit programme, which has been restricted due to capacity within the Transfusion team rather than wider organisational ownership. This is part of the engagement process that transfusion sit within divisions. If engagement, ownership and accountability is improved, then the delivery of incident investigations and the audit programmes will be a

collaborative rather than being reliant on the Transfusion team. This is on the risk register as a compliance issue.

The report also mentions the development of the dementia nurse role and a steer was requested from the Quality Committee on how to take this forward. AD stated that there is a vacancy within the corporate nursing team related to dementia and this is an opportunity to see what is happening in other organisations and how we can inform the vacancy going forward, as an element of improvement work is required. The post is currently not out to advertisement, and any suggestions were welcomed. It was stated that this may also link into the mental health strategy.
Action: MT to check with LR and feedback.

101/20 QUALITY PRIORITIES PAPER

AD presented appendix F to enhance the conversation regarding the stabilisation and reset agenda and what the quality priorities need to look like going forward.

The paper describes the programme of work around quality priorities where governors and staff were involved to choose three priorities which were set out in early March 2020 and agreed. There were additional quality priorities which the quality leads (AD, EA, CP, LR and DB) identified needed to be in parallel to the three quality priorities. The additional seven quality priorities are:

- Clinical documentation
- Personal Protective Equipment (PPE)
- Medical Devices
- End of Life Care
- Falls resulting in harm
- Deferred care pathways due to Covid-19/ and how these relate to the mortality of Covid and non Covid death
- New ways of working

Clinical Documentation – this has been an ongoing challenge in the organisation and a significant piece of work was done in relation to the transformation and launch of the Cerner system across the organisation. There was a recent paper presented to the Digital Health Forum which looked at our standard ward assurance document which audits clinical records and when the report was presented in February 2020, it described limited assurance from recent auditing of clinical records, and raised some concerns on the sustained improvement journey. Record keeping should be an accurate reflection of the care of a patient and should be describing the patient's story, what their diagnosis and priorities are, and their journey through the organisation. The initial stocktake raised some concern, and there are some improvements on the limited assurance

Personal Protective Equipment (PPE) – the PPE Group was established early during the COVID-19 pandemic and continues to meet daily to determine a strategy going forward. The group has established several measures around patient safety and the staff experience by having the right level of PPE to deliver care. A significant amount of work has been done in the Group, with further work yet to be completed, and given the current challenges with the supply chain, this piece of work will need to continue going forward.

Medical Devices – this group was established to review medical devices to support the pandemic and deployment of equipment across the organisation. The group gave a clear steer of work that needed to be done and identified gaps in the assurance processes that need to be addressed and progresses to ensure patient safety is maintained.

End of Life Care – there is an end of life strategy 2019-2021 with three key priorities, however, this is about the provision of compassionate and person-centred end of life care, and to keep as a high priority on the Trust's agenda. The National Audit of Care at End of Life (NACEL)

audit was undertaken with some improvements made, but there was an opportunity to improve.

Falls resulting in harm – Upon reviewing some of the reports on trends across the organisation, slips, trips and falls remains the highest type of incident being reported. This scheme is looking at a reduction in the number of falls that result in harm. There is a falls collaborative which is steering this work going forward.

Deferred care pathway – this is looking at pathways that were deferred as a result of COVID-19 and how to understand the impact on a patient perspective and the outcome measures of that going forward.

Business better than usual – there has been a piece of work ongoing in response to the COVID-19 pandemic looking at how to do things differently – *business better than usual* - and capturing the learning in organisation and ensuring that those changes made are evaluating and positively impacting on the patient's experience of safety and quality, and ensuring a plan for a more sustainable implementation.

EA stated that the refreshed priorities are reflective of the journey through COVID-19 and beyond. EA also stated that infection prevention and control is incredibly important and may need to be added as a clinical priority, following further assurance seen by the Quality Committee, particularly around the nosocomial infections. The recommendation was to agree the priorities and refresh them at the end of the financial year, and work as a group to swiftly define the expected outcome measures.

It was further stated that these were the Committee's top priorities of focus at this point in time, and that there will be further priorities, however, the agreement which was reached before COVID-19 was that a shorter set of quality priorities were needed to give an overview of how successful we are as an organisation in terms of managing some of those risks. It was accepted that if there was a second COVID-19 surge, the priorities would need to be further reviewed.

Various comments were made on this being a good step forward in terms of clarifying a reasonable number of priorities. It was also stated that any key priorities are fed into the relevant stabilisation and reset meetings.

Ideas of how outcomes could be measured going forward were welcomed from the Committee. Regarding clinical documentation and the reduction in legal claims, it was stated that it can take up to three years for a legal claim to be completed, therefore it was uncertain how immediate this measure would be and suggested that complaints would be a timelier measure. It was also stated that the starting point for all the measures would need to be identified first in order to be specific on what the reduction would be.

It was asked how much information is being gathered about the impact of poor clinical documentation on discharge planning, and it was stated that some of this is being gathered through incident reporting within and from other organisations relating to interface-type incidents. There are standards on record keeping published by several bodies, therefore will need to audit against those standards to understand any improvements.

AD was happy to receive comments outside of the meeting to inform what success measures could look like.
Action: Committee members to contact AD with any thoughts on the paper.

102/20 LEARNING FROM DEATH ANNUAL REPORT

CP presented appendix G which comprises of two parts:

- the learning from deaths annual report which covers an 11-month period due to the outbreak of COVID-19, and focuses on divisional assurance in relation to modes of

examining deaths in the organisation, and whether the processes cover a representative sample of deaths; and
- COVID-19 mortality review for deaths between 23 March and 19 May 2020.

In relation to learning from deaths, the mortality metrics continue to move in the right direction, with crude mortality declining, Hospital Standardised Mortality (HSMR) continuing to be a positive outlier with the latest figure at 88.6%, and the Summary Hospital-level Mortality (SHMI) remains within expected limits at 98.6%.

Two level of reviews are conducted on death, the first being the initial screening reviews which are delivered across the specialities, with a target set at 50%. This was not achieved during the 11-month period, and currently stands at 32%, largely due to reviews being suspended during the COVID-19 pandemic and clinicians being released for front-line clinical activity. The second level of reviews – structured judgement reviews did continue, and 128 deaths were reviewed over the period. Particular interest was in whether there was assurance that divisions were acting on very poor scores. This was audited and found that 15 out of 17 deaths were escalated to the divisions and the outcomes of those are detailed in the paper. The other two deaths were still in process of the audit.

In terms of demographics and whether a representative sample of deaths were being reviewed, this was found to be correct. Gender and ethnicity were approximate to our ethnic and gender distribution across all deaths, and the same was for initial screening reviews. For the structured judgement reviews, it was found that a slightly younger population were being reviewed, which was not surprising as the potential for avoidability may be regarded as being higher in that younger age group. In terms of ethnicity, the cases reviewed matched deaths across the hospital; but for all patient contacts, the ethnic breakdown was 79% white and 13% black, Asian and minority ethnic (BAME), but for mortality, there was a greater proportion of individuals who were white, at 87%.

In relation to COVID-19 review of deaths between 23 March and 19 May 2020, there were 348 inpatient deaths, of those, 140 were COVID-19 positive. Peak mortality occurred week commencing 10 April 2020 which coincided with the national peak, but was a week earlier than other Trusts in the region. During COVID-19, there was an overall 31% increase in the total number of COVID-19 positive and non-COVID-19 deaths. When COVID-19 deaths were excluded, there were fewer non-COVID-19 deaths than in the same time period the year previously. The majority of patients who died had multiple co-morbidities, and there was a sense that patients coming into hospital without COVID-19 were sicker, due to them delaying coming into hospital. This was examined to see if there was any evidence to support that. The admission NEWS score was reviewed, and there was some evidence. The mean NEWS score before COVID-19 was 4.3 and during COVID-19 it was 5.6. A NEWS score of 5 or more is a key threshold for an urgent clinical alert and response. Demographics were also reviewed and in common with the national picture, CHFT figures were almost identical in that twice as many males died than females, and again in keeping with the national picture, our population were older compared to the normal mortality profile. The ethnicity data was also reviewed, and the ethnicity of those who died from COVID-19 and those who did not, was very similar to the normal mortality profile, however, the same pattern was not seen nationally in this instance, that more of our deaths took place proportionately in the white population rather than the BAME population. Further analysis is yet to be done on this, and it is possible that the BAME deaths took place in a slightly younger population. This analysis has just been completed for the COVID-19 deaths, and if a patient died from COVID-19 at CHFT and came from a BAME background, the average age of death was 37.9, compared to if a patient was white, with an average age of death being 53.5.

The recommendations from the paper over the next 12 months will link into the newly appointed lead Medical Examiner's team, and work alongside the learning from deaths process.

It was asked if there was any information regarding deaths in the community and if there was an increase in patients who died at home. It was stated that this data was not available, however, some people who died with COVID-19 may have had multiple co-morbidities.

Regarding the 50% of all in-patient deaths being subject to initial screening by June 2021, it was asked whether the target was realistic. CP stated that the target is realistic but is dependent on whether there is a second COVID surge, which will take clinicians out of their non-clinical roles.

103/20 INFECTION PREVENTION AND CONTROL BOARD ASSURANCE FRAMEWORK

DB presented appendix H, the infection prevention and control (IPC) board assurance framework which was released by NHS England and NHS Improvement on 4 May 2020, as a voluntary assessment to support organisations in providing assurance around processes in place to manage COVID-19 from an infection control perspective.

CHFT completed the assessment using independent colleagues who previously worked for the Trust, who provided an independent assessment against the 10 standards included in the report. Overall, they provide a broad level of assurance around the Trust's approach to IPC in relation to COVID-19. Each standard is detailed in the report, as well as the assurance found, and a small number of actions needed to take forward. An action plan will be developed around the board assurance framework moving forward.

Despite the assessment being voluntary, there are now requests from the CQC to show that this has been received by the organisation and by the Board, and whether it has been completed. It was stated that the five weeks since the assessment took place is a long time in relation to COVID-19, with changes taking place on a weekly basis with more guidance being published. The Trust has moved on substantially since then, and the assessment is from a point in time. It is felt that these assessments may need to continue to take place as new guidance is published, to ensure that CHFT are responding appropriately against the recommendations.

It was stated that recommendation 2 – *'improve the communication between the various visiting teams to ensure consistency of messages'* – is quite a challenge with the fact that colleagues are working in different places trying to be as supportive as they can. It was asked how this will be addressed, and DB stated that it has been a challenge and were conscious of how to communicate quite complex issues, and a lot was unknown about COVID-19 in the beginning which has now improved, and were using the usual mechanisms of communication in terms of the daily briefing messages; a number of forums, both medical and nursing; red border emails which were used to communicate urgent pieces of communication; using the intranet; screensavers and using the communications team to ensure messages were circulated in a consistent manner, however, there were some concerns on occasion that colleagues felt they were not up to speed with guidance that may have changed on a very frequent basis. Every mode of communication open to us will continue to be used.

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: Action plan to be brought back to the Committee at a later date.

104/20 QUALITY COMMITTEE TERMS OF REFERENCE

An amended copy of the terms of reference were available at appendix I, to note the addition of the Clinical Director of Pharmacy as a permanent member of the Committee, and the change from the Executive Director of Workforce and Organisational Development to the Deputy Director of Workforce and Organisational Development as a permanent member.

105/20 ANY OTHER BUSINESS

CM stated that the general public may have a rough idea of what staff have been through during COVID-19, but from seeing the extra administration, caring and medical work that has been done, a big thank you was conveyed to everyone for the work carried out over the past few months.

106/20 MATTERS TO REPORT TO THE BOARD OF DIRECTORS

- The quality priorities were agreed and supported by the Committee
- The infection, prevention and control (IPC) board assurance framework was also received

107/20 EVALUATION OF MEETING

This item was not taken.

108/20 QUALITY COMMITTEE ANNUAL WORK PLAN

A copy of the workplan was available at appendix J and the Chair stated that the agenda items which were deferred will be back on schedule within the next few meetings.

NEXT MEETING

Monday, 3 August 2020
3:00 – 4:30 pm
Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 29 JUNE 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
UPCOMING ACTIONS				
29.6.20 (100/20	**PATIENT SAFETY REPORT**	Maxine Travis	The report mentioned the development of the dementia nurse role and a steer was requested from the Quality Committee on how to take this forward. AD stated that there is a vacancy within the corporate nursing team related to dementia and this is an opportunity to see what is happening in other organisations and how we can inform the vacancy going forward, as an element of improvement work is required. The post is currently not out to advertisement, and any suggestions were welcomed. It was stated that this may also link into the mental health strategy. **Action 29.6.20**: MT to check with LR and feedback.	**UPDATE DUE Monday, 3 August 2020**
29.6.20 (101/20)	**QUALITY PRIORITIES PAPER**	Andrea Dauris	AD was happy to receive comments outside of the meeting to inform what success measures could look like. **Action 29.6.20**: Committee members to contact AD with any thoughts on the paper.	**UPDATE DUE Monday, 3 August 2020**
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 DUE Monday, 3 August 2020**
3.6.19 (108/19) 1.7.19 (123/19) 29.7.19 (action log) 30.9.19 (action log) 2.12.19 (action log) 6.1.20 (action log) 2.3.20 (40/20)	**MENTAL HEALTH STRATEGY** Lindsay Rudge (Deputy Chief Nurse) reported that the three year mental health strategy, which is being developed in line with the Trust strategy and aligns to the Treat as One document, will be submitted to the Weekly Executive Board, and be brought to the next Quality Committee meeting in July.	All Lindsay Rudge	**Action 3.6.19**: Mental health strategy to be received next month **Update June 2019:** Mental Health Strategy to be forwarded to Committee for comments to Lindsay by 15 July 2019 **Update 29.7.19:** This item to be deferred as further engagement needed. A draft paper for arrangements in the organisation will provide assurance to the Quality Committee on standards expected. A definitive paper will be available at the end of September. **Update 30.9.19**: Update provided – see item 177/19 **Action: 30.9.19**: Written update to be provided in October 2019 **Update November**: For strategy to be deferred to December **Update 2.12.19:** Report still in draft and due for submission to Quality Committee in January 2020 **Update 6.1.20**: Strategy still in development – to be deferred to the next meeting. **Additional update:** Strategy to be deferred to March, along with the Policy and training plan **Update 2 March 2020**: See item 40/20. The draft strategy and terms of reference were presented. Comments on the terms of reference to be forwarded to LR in the next 2 weeks. **Action 2.3.20**: Any comments on the terms of reference to be forwarded by Monday, 16 March 2020. **Action 2.3.20**: The amended terms of reference along with the mental health policy and training plan to return to Quality Committee for the next meeting **Update June 2020: It has been agreed that the strategy, terms of reference, mental health policy and training plan will be presented at the meeting on 3 August 2020**	**DUE Monday, 3 August 2020**
2.3.20 (43/20)	**CLINICAL RECORD KEEPING** **(as part of CQUINS update)**	Lindsay Rudge	**Action 2.3.20**: Paper to be provided on clinical record keeping **Update June 2020: It has been agreed that the clinical record keeping paper will be presented at the meeting on 3 August 2020**	**DUE Monday, 3 August 2020**
ACTIONS DUE LATER IN THE YEAR				
1.7.19 (120/19) 2.3.20 (41/20)	**COMPLAINTS DEEP DIVE**	Owen Williams	**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 DUE Monday, 28 September 2020**
5.2.20 (21/20)	**OUTPATIENTS IMPROVEMENT PLAN**	Katharine Fletcher / Helen Barker	**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**	**UPDATE DUE Monday, 28 September 2020**
CLOSED ACTIONS				
2.3.20 (45/20)	**HIGH LEVEL RISK REGISTER – GOVERNANCE PROCESS**	Maxine Travis	**Update 2.3.20**: Following discussion around the reduction of risks, it was suggested that the governance process is reviewed in order for the Quality Committee to initially agree a risk reduction before being considered at the Risk and Compliance Group. **Action 2.3.20**: Governance process to be reviewed **Update: The governance process remains that Divisional PSQBs and DMTs review their risks and propose those for escalation to ≥15. These are then discussed through the Risk and Compliance Group, who then proposes the Quality-related risks to Quality Committee for discussion and agreement, which then goes onto the high-level risk register prior to the Board of Directors.** **The issue regarding the reduction of the complaints risk (6493) at the March meeting should not have taken place before there was any evidence that the impact of actions could be sustained and mitigated in the longer term.**	**CLOSED Monday, 29 June 2020**
2.3.20 (50/20)	**SELF-ASSESSMENT**	Committee members	**Update 2.3.20:** A link to the self-assessment forms for completion by the core committee members was circulated, and to be submitted by Monday, 16 March 2020. **Action 2.3.20**: Responses to be submitted by Monday, 16 March 2020 **Update June 2020: Due to the annual report being deferred to August 2020, a new self-assessment form will be circulated, with responses required one week later.**	**CLOSED**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 3 August 2020

STANDING ITEMS

109/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Andrea Dauris **(AD)**	Associate Director of Nursing, Quality and Safety
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Andrea McCourt **(AMcC)**	Company Secretary
Christine Mills **(CM)**	Public-elected Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lucy Walker **(LW)**	Quality Manager, Calderdale & Huddersfield CCG
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Suzanne Dunkley **(SD)**	Director of Workforce & Organisational Development (item 119/20)
Adam Matthews **(AM)**	Workforce Reconfiguration Lead (item 119/20)

110/20 APOLOGIES

Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Maxine Travis **(MT)**	Senior Risk Manager

111/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

112/20 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Monday, 29 June 2020 were approved as a correct record.

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

MATTERS ARISING

113/20 MENTAL HEALTH POLICY / TERMS OF REFERENCE

Lindsay Rudge (Deputy Director of Nursing) reported that the mental health strategy and terms of reference for the mental health clinical network were submitted to the Quality Committee in March 2020 (see item 40/20 of the Quality Committee minutes) and were approved and signed off.

The mental health policy was drafted by Janet Youd (Emergency Nurse Consultant) and Vicky Thersby (Safeguarding Lead), however, the development was slowed down due to colleague deployment during the pandemic. Work is also ongoing on the Policy with partners at South West Yorkshire Partnership NHS Foundation Trust and their mental health act legal team, which has caused a further delay, however, this is nearly complete.

A copy of the stabilisation and reset operational group terms of reference will be circulated to the Committee.

Action: Stabilisation and reset operational group terms of reference to be circulated.

LR reported that a meeting with CP is scheduled to ensure that the strategy contains the relevant information, post-COVID, and following the presentation at item 119/20 on health and well-being which focusses on staff mental health, it is anticipated that there may be an increase in issues related to mental health through our services.

114/20 CLINICAL RECORD KEEPING

Lindsay Rudge (Deputy Director of Nursing) presented appendix C which provided an overview of the ward assurance clinical record audit. The paper was also presented to the Weekly Executive Board in February 2020.

The audit resulted in low compliance against quality standards expected through clinical documentation on the electronic patient record, and also served as a prompt of the enforcement action received from regulators during an inspection on record keeping. A number of recommendations were made including:

- To review and strengthen the governance of the clinical records group;
- To develop a combined nursing and medical overview page of outstanding tasks;
- To provide a weekly extract of the data into the Weekly Executive Board report for monitoring and performance management;
- A Work together to get results (WTGR) session to understand the workflows;
- To review training package
- Divisional and directorate management teams to provide leadership support to improvement activities required to increase compliance.

LR noted this as one of the quality priorities and outlined to the Committee the position before COVID-19. The Committee were asked to support recommendations made.

KH queried if there was a timescale attached to the work, to which LR confirmed as being an immediate focus of delivery of improvement to drive performance back to expected levels. It was also stated that a progress update and action plan can be provided at the next meeting. **Action**: Progress update to be provided to the next Committee meeting.

The Chair asked when the work together to get results session would be and what some of the known barriers were. LR stated that barriers include the multiple ways that specific information can be recorded in the clinical record and bypasses to some of the routes of extraction. A fair amount of training needs to be undertaken to direct colleagues to where information should be documented in the clinical record, however, it is not yet known what alterations can be made to stop other fields being visible. A focused piece of work will be done to ensure that correct medical representation is on the clinical records group, as one of the recommendations related to divisional and directorate leadership. It will be critical to have the correct governance and engagement to ensure there is clarity on cross-cutting issues, as well as divisional-specific issues.

OUTCOME: The Quality Committee were in support of recommendations made.

SUB-GROUP REPORTS

115/20 PATIENT EXPERIENCE AND CARING GROUP REPORT

Lindsay Rudge (Deputy Director of Nursing) acknowledged and gave particular thanks to Amanda McKie (Matron Lead for learning disabilities and deputy chair of the patient experience and caring group) and Alison Lodge (Quality improvement manager for patient experience) who have both kept the patient experience and caring group meetings ongoing while LR was absent, and also having oversight of patient experience priorities and ensuring they were supported in response to COVID-19.

LR presented appendix D which highlights the output from the patient experience and caring group on end of life care work, ongoing work with the friends and family test, and the national inpatient survey action plan.

The Chair stated that the comprehensive report provides a good oversight on the amount of work undertaken as well as the innovative initiatives by individual areas. Thanks were conveyed to all those involved.

SAFE

116/20 INTEGRATED PERFORMANCE REPORT

Ellen Armistead (Executive Director of Nursing) reported on the Integrated Performance Report (IPR) at appendix E noting the decrease in performance in the safety domain, the first domain to register a red RAG rating in over 12 months. This was a combination of a never event, access to diagnostics targets, appointment slot issues and 52 week waits.

There is a need to review dashboards at ward level for rapid reporting in order to take any action needed in a timely manner. One of the quality priorities is clinical prioritisation which is important in striking the balance in getting back to enabling people to access our services while at the same time treating those in greatest clinical need.

David Birkenhead (Medical Director) reported on concerns around clostridium difficile, as there seems to be a small increase in isolated cases across the region and trying to understand why this is happening. This could be due to increased antibiotic usage, either in the community or in the organisation as a result of COVID-19. This is being monitored.

LW asked if the Trust were addressing the appointment slot issues that were above and beyond the stabilisation and reset meetings, as there have been queries in the Clinical Commissioning Groups. EA stated that there was a programme of work on the longer-term outpatients' transformation and the legacy issues which have been in the system for quite some time. The action plan is now being reviewed and Kimberley Scholes (Business Manager for Outpatient Services) is due to attend this meeting again to provide an update on work done on the legacy issues prior to COVID-19.

KH noted that the return to work interviews were decreasing and saw this as an opportunity to link into the wellbeing of colleagues returning to work. KH also noted that the unconditional offers to acceptance on recruitment seems to be high and asked if this was due to people taking time to decide or whether this was on the Trust's part? EA stated that the governance structure which supports the Quality Committee has been reviewed and there have been gaps in the high-level triangulation over and above of what is seen in the integrated performance report, and within the next few months, meetings will be taking place to consider exit data, freedom to speak up, complex complaints and complex serious incidents, and triangulate the learning to feed into the Quality Committee. It was stated that the IPR is useful in providing a detailed overview, however, it would also be helpful to take one or two pieces of information to review in further detail.

The Chair stated that even though COVID-19 can be used to explain and justify some of the reductions in performance, we still need to ensure that every opportunity is used to move back in the direction we need to be.

117/20 BOARD ASSURANCE FRAMEWORK 2020 / 2021

Andrea McCourt (Company Secretary) presented appendix F and reminded the Quality Committee that the risks on the Board Assurance Framework relate to achieving strategic objectives, and are on for a longer period than the operational risk register.

The Board Assurance Framework for 2020 / 2021 shows a significant amount of movement and reflects the revised 10-year strategy and the impact of the COVID-19 pandemic on the strategic objectives.

Each risk has a responsible Committee, and the Quality Committee is the lead for five of the risks on the Board Assurance Framework:

- 3/19 - Seven-day services
- 4/19 - Patient and Public Involvement
- 6/19 - Compliance with quality & safety standards
- 9/19 - HRI estate and equipment (impact quality)
- 4/20 - CQC rating

The Quality Committee were asked to note the removal of one risk (5/19 - Electronic Patient Record benefits realisation), which has been on the Board Assurance Framework for three years and reached its target score. This was agreed at the Audit and Risk Committee as appropriate. A digital risk has also been added (2/20 - Investment to fund Digital Strategy).

Of the six new risks added, one relates to the CQC rating which the Quality Committee is a lead on and scoring 12. The Quality Committee are asked to agree that this is added to the Board Assurance Framework today.

It is expected that a health inequalities risk will be added to the risk register in August or September 2020, however, some national work is awaiting completion, which will inform the risk.

Information on risk exposure has been added to the report, which is where the risk score is greater than the risk appetite. There is new risk (5/20 – service capacity due to COVID-19) in the harm and safety category which is scoring above the risk appetite. The lead Committee for this is the Trust Board, however, the Quality Committee may also want to be sighted on this.

There are two staffing risks (10a/19 Medical Staffing and 10b/19 Nurse Staffing) which have both the Workforce and Quality Committees as the responsible committees, however, from a governance perspective, it is not clear where the responsibility lies, and discussion is needed on which Committee should lead on the risks.

Board Committees are now being asked to closely review their risks and build them into their work plans. It was suggested that the Quality Committee carry out a deep dive on one risk per month between now and the end of the financial year, and a steer from the Committee is needed on how this can be done, possibly based on the RAG rating of the risks, and to also consider the annual strategic plan. The Chair acknowledged responsibility to liaise with the executive leads for the risks to take their view on how this is progressed.

OUTCOME: The Quality Committee accepted the recommendations as outlined in the report and agreed that the Workforce Committee will lead on the two staffing risks.

Further discussion is needed at the next meeting on how to undertake the deep dive work between now and the end of the financial year, and AMcC reported the further work is needed on the Board Assurance Framework to review the gaps in controls to ensure there are clear actions associated with each risk.

WELL-LED

118/20 CQC UPDATE AND INFECTION PREVENTION AND CONTROL ASSESSMENT

Ellen Armistead (Executive Director of Nursing) provided an overall CQC update and reported that the Trust has a good relationship with the CQC and had positive engagement meetings. The emergency support framework currently in place is set to continue for the foreseeable future and likely to be moving to a more digital-based assessment process for submitting evidence. The CQC preparation is now in the process of merging with the ward accreditation

programme with less duplication to reflect the CQC likely areas of focus if they come in. The Trust is not aware of any forthcoming inspections but will always remain prepared.

David Birkenhead (Medical Director) reported on the infection prevention and control (IPC) assessment at appendix G and congratulated the IPC team and the rest of the organisation for achieving this response.

Prior to the submission to CQC, the Trust had a self-assessment approach to COVID-19, and with external assurance, achieved all eleven standards. Some areas of good practice were also noted in the report.

It was noted that the report was a very positive read and congratulations were conveyed to all involved.

119/20 COVID-19 HEALTH AND WELLBEING RISK ASSESSMENT

Suzanne Dunkley (Director of Workforce and Organisational Development) and Adam Matthews (Workforce Reconfiguration Lead) were in attendance to provide an overview of the COVID health and wellbeing risks assessments and mitigations which are categorised by physical, mental health and personal circumstances.

The number of mitigations addressing mental health risk factors are far-ranging, and was suspected that not many people would be discovered that were not already known to have high physical risk factors, however, there was one example of where a colleague with serious underlying health conditions was missed by the national shielding letter, and therefore not formed part of our shielding group.

Within 24 hours of the risk assessment, 99% of calls were made to colleagues who were feeling very anxious. From a physical point of view, where there may be a colleague with high physical risk factors and working in an area of high risk (red zone), consideration was made whether to automatically, under our duty of care, remove that colleague from that area or recognise the need to involve the colleague in that decision. It was thought that the duty of care should be taken, however, feedback suggested that the decision could be undermining for some colleagues and would take away their personal responsibility for their own health and wellbeing. Another physical risk mitigation is for colleagues to undertake a one-to-one meeting with managers to map their individual physical risk versus the place they work, which should be taken as a combined response.

In terms of mental health mitigations, a 24-7 helpline has been offered, which has relied heavily on internal colleagues to support, however, support has been gained from an external company called Socrates that specialises in cognitive behavioural therapy and post-traumatic stress disorder, and colleagues have been triaged through that route for a while. In response to the staff survey, it is suggested that that is continued and to resource a bid to the Commercial Investment and Strategy Group to keep the 24/7 helpline running.

Our response to COVID-19 has been co-developed with the engagement team in Workforce and Organisational Development and also our team of psychologists. One issue which has been reflected on recently, is that in the Ministry of Defence, or in firearms protection of the Police Force, every year, their colleagues are given a psychological test to check that they are safe to do their job. Given what colleagues have been through over the last several weeks, it is suggested that the same is done in a healthcare setting for colleagues who may be carrying some severe mental health issues who are being asked to provide care to patients.

The Trust wants to talk more about mental health wellbeing and to normalise mental health by carrying out a few exercises such as a very focused response to certain areas like ICU and critical care, who are showing acute signs of mental health issues both as a team and as individuals, and also looking at ways to normalise mental health and mental health issues which may include some high profile colleagues talking about their own mental health.

Another result that the risk assessment has shown is that the known higher-risk factor groups – men, people aged over 55, black, Asian and minority ethnic (BAME) colleagues, and people with underlying health conditions are returning the risk assessment forms in lower numbers than white colleagues. The health and wellbeing risk assessment was taken to the BAME network meeting and suggestions were provided on what could be done to improve completion, including BAME colleagues volunteering to help the engagement team to promote the risk assessment, and talking to colleagues to gain intelligence as to why certain groups are not responding to the risk assessment.

In terms of personal circumstance risk factors, the most levels of anxiety were about schools not reopening, childcare, public transport, etc, and mitigations for these are identifying flexible approaches for colleagues.

Some other mitigations were also considered but not adopted and would be good to audit those decisions and why they were not taken.

Discussion took place on the leadership development programme including mental health and how learning can help colleagues deal with trauma; how the suggestion of undertaking psychological test for colleagues would be beneficial; breaking the stigma of mental health and sharing stories; and how to balance working from home.

EA stated that this is not a health and wellbeing assessment to be completed following an event, but that this will be the way we work going forward, to embody one culture of care. Concern regarding engagement with BAME colleagues was also raised and more needs to be done as a senior leadership team to engage in a more productive way, by having well-being champions reflecting the workforce.

Ongoing communication needs to remain in place to reassure colleagues that the risk assessments are designed to help.

ES reported that it was good to see a lot being done to support colleagues and their wellbeing. Whilst the clinical workforce are being supported in terms of their risk assessment and managers are being very supportive of colleagues working from home, there is a risk as a service and department, that some colleagues may not be doing their job as well as they could, for example pharmacists missing clinical reviews and patient contact, which is really important to be done with the patients directly. There's also a risk that there will be less staff in a service or department if they are being taken out for wellbeing activities. SD stated that consideration had been taken as to whether this would have a negative impact, or whether not allowing it will have more of a negative impact; and if colleagues are not allowed to have time to themselves, there may be a disastrous and devastating dip in attendance at work. SD stated that the well-being of colleagues will be done on a regular basis and that the balance between service provision and patients and colleagues will be a challenge.

Action: Any comments on the COVID health and wellbeing risk assessment to be forwarded to SD.

RESPONSIVE

120/20 QUALITY ACCOUNT – FIRST DRAFT

AD presented the first draft of the quality account at appendix I, which is in line with revised timeframes, and circulated to key stakeholders for comment. The report is a statutory requirement, and due to the timeframes being reset, a full years' worth of data has been included, with the exception of the guardians of safe-working.

The Committee are asked to review the document and provide any comments by Monday, 17 August 2020.

Action: Comments on the first draft of the Quality Account to be forwarded to AD by Monday, 17 August 2020.

121/20 ANNUAL REPORT

AD presented the Quality Committee's annual report at appendix J which describes the Committee's activity between April 2019 and March 2020.

The paper provides an overview of the role of the Quality Committee, details of the membership and their attendance between the timeframes, and information on the work of Committee broken down into areas of quality improvement, governance and risk, patient safety, audit and assurance, and quality and safety reporting. Reference has also been made to the results of the effectiveness of the Committee, which will be placed into an action plan and submitted to the Quality Committee.

The Committee were asked to review section four of the report to decide if the functions of the Committee were fulfilled, and to note the next steps for 2020 / 2021.

OUTCOME: The Quality Committee accepted the report.

Action: An action plan will be submitted to the Committee once the results have been reviewed.

POST MEETING REVIEW

122/20 MATTERS TO REPORT TO THE BOARD OF DIRECTORS

- Report received on the clinical record keeping audit with limited assurance of accurate documentation of clinical care
- Report received from the patient experience and caring group, which was a very strong report in terms of initiatives underway and completed.
- Integrated performance report - to note the reduction in the safe domain
- CQC infection prevention and control assessment – the Trust achieved all eleven standards

123/20 REVIEW OF MEETING

What went well….

- The reports were very easy to understand and very open and honest
- The meeting went really well in a short space of time

What could be better……

- Need to start considering quality priorities at every meeting
- The meeting papers being circulated on time

124/20 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

125/20 GROUND RULES FOR MEETINGS

The Chair noted the meeting ground rules at appendix K and asked the Committee to review.

126/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix L, and will be amended to include the quality priorities, as well as the risks from the Board Assurance Framework.

NEXT MEETING

Monday, 2 September 2020 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 3 AUGUST 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
UPCOMING ACTIONS				
3.6.19 (108/19) 1.7.19 (123/19) 29.7.19 (action log) 30.9.19 (action log) 2.12.19 (action log) 6.1.20 (action log) 2.3.20 (40/20) 3.8.20 (113/20)	**MENTAL HEALTH POLICY** Lindsay Rudge (Deputy Chief Nurse) reported that the three year mental health strategy, which is being developed in line with the Trust strategy and aligns to the Treat as One document, will be submitted to the Weekly Executive Board, and be brought to the next Quality Committee meeting in July.		**Action 3.6.19**: Mental health strategy to be received next month **Update June 2019:** Mental Health Strategy to be forwarded to Committee for comments to Lindsay by 15 July 2019 **Update 29.7.19:** This item to be deferred as further engagement needed. A draft paper for arrangements in the organisation will provide assurance to the Quality Committee on standards expected. A definitive paper will be available at the end of September. **Update 30.9.19**: Update provided – see item 177/19 **Action: 30.9.19**: Written update to be provided in October 2019 **Update November**: For strategy to be deferred to December **Update 2.12.19:** Report still in draft and due for submission to Quality Committee in January 2020 **Update 6.1.20**: Strategy still in development – to be deferred to next meeting. **Additional update:** Strategy to be deferred to March, along with the Policy and training plan **Update 2 March 2020**: See item 40/20. The draft strategy and terms of reference were presented. Comments on the terms of reference to be forwarded to LR in the next 2 weeks. **Action 2.3.20**: Any comments on the terms of reference to be forwarded by Monday, 16 March 2020. **Action 2.3.20**: The amended terms of reference along with the mental health policy and training plan to return to Quality Committee for the next meeting **Update June 2020:** It has been agreed that the strategy, terms of reference, mental health policy and training plan will be presented at the meeting on 3 August 2020 **Update 3.8.20:** The mental health policy was drafted by Janet Youd (Emergency Nurse Consultant) and Vicky Thersby (Safeguarding Lead), however, the development was slowed down due to colleague deployment during the pandemic. Work is also ongoing on the Policy with partners at South West Yorkshire Partnership NHS Foundation Trust and their mental health act legal team, which has caused a further delay, however, this is nearly complete. A copy of the stabilisation and reset operational group terms of reference will be circulated to the Committee. **Action 3.8.20: Stabilisation and reset operational group terms of reference to be circulated.**	**COMPLETED**
2.3.20 (43/20) 3.8.20 (114/20)	**CLINICAL RECORD KEEPING** **(as part of CQUINS update)**	Lindsay Rudge	**Action 2.3.20**: Paper to be provided on clinical record keeping **Update June 2020:** It has been agreed that the clinical record keeping paper will be presented at the meeting on 3 August 2020 **Update 3.8.20: LR confirmed as being an immediate focus of delivery of improvement to drive performance back to expected levels. It was also stated that a progress update and action plan can be provided at the next meeting.** **Action 3.8.20: Progress update to be provided to the next Committee meeting.**	**DUE** **Wednesday, 2 Sept 2020** **SEE AGENDA**
3.8.20 (119/20)	**COVID-19 HEALTH AND WELLBEING RISK ASSESSMENT**	**All**	**Action 3.8.20: Any comments on the COVID health and wellbeing risk assessment update on mitigations and next steps to be forwarded to SD.**	
3.8.20 (120/20)	**QUALTIY ACCOUNT – FIRST DRAFT**	**Andrea Dauris**	**Action 3.8.20: Any comments on the first draft of the Quality Account to be forwarded to AD by Monday, 17 August 2020.**	
ACTIONS DUE LATER IN THE YEAR				
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.**	**UPDATE DUE** **Monday, 28 Sept 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 DUE** **Monday, 28 September 2020**
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**	**UPDATE DUE** **Monday, 28 September 2020**
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 DUE** **Monday, 28 September 2020**
CLOSED ACTIONS				
29.6.20 (101/20)	**QUALITY PRIORITIES PAPER**		AD was happy to receive comments outside of the meeting to inform what success measures could look like. **Action 29.6.20**: Committee members to contact AD with any thoughts on the paper. **Update 3.8.20: AD has now received comments and responses on the quality priorities, and meetings with leads for further development are taking place.**	**CLOSED** **Monday, 3 August 2020**
29.6.20 (100/20	**DEMENTIA NURSE ROLE (Part of patient safety report)**		The report mentioned the development of the dementia nurse role and a steer was requested from the Quality Committee on how to take this forward. AD stated that there is a vacancy within the corporate nursing team related to dementia and this is an opportunity to see what is happening in other organisations and how we can inform the vacancy going forward, as an element of improvement work is required. The post is currently not out to advertisement, and any suggestions were welcomed. It was stated that this may also link into the mental health strategy. **Action 29.6.20**: MT to check with LR and feedback. **Update 3.8.20: LR reported that she has met with Renee Comerford (Consultant Nurse for Older People) who is writing a draft job description for an Associate Nurse Consultant which will incorporate the dementia work.**	**CLOSED** **Monday, 3 August 2020**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE
Held on Wednesday 15 July 2020, 12.45pm. – 1.45pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
Helen Barker	(HB)	Chief Operating Officer
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	(AM)	Company Secretary
Sharon Senior	(SS)	Staff Side Representative
Denise Sterling	(DS)	Non-Executive Director
Linzi Smith	(LS)	Staff Governor

IN ATTENDANCE:

Philip Lewer	(PL)	Chairman

18/20 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

19/20 **APOLOGIES FOR ABSENCE:**

Jude Goddard, Public Governor

20/20 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

21/20 **MINUTES OF MEETING HELD ON 18 FEBRUARY 2020:**

The minutes of the Workforce Committee meeting held on 18 February 2020 were approved as a correct record.

The Committee meetings scheduled to take place in April and June 2020 were cancelled due to the Covid-19 pandemic.

Workforce matters were discussed at joint meetings of Quality and Workforce on 4 May and 1 June 2020. The Workforce section of the notes were shared with members today.

22/20 **MATTERS ARISING**

There were no matters arising.

23/20 **ACTION LOG**

The action log was reviewed and updated accordingly.

Appendix A

24/20 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JUNE 2020**

Performance on workforce metrics continues to be high although the Workforce domain decreased to 82.6% in June 2020. This is now 14 consecutive months of a 'Green' domain.

Only 3 of the 17 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 activity as a consequence of Covid-19. It was however noted that the appraisal season for non-medical colleagues opened on 1 July and will close on 31 October.

Workforce – May 2020

The Staff in Post increased by 5.3 FTE, which, due, in part, to 30.08 FTE new starters in May 2020. This led to a decrease of 7.35 FTE vacancies.

Turnover increased to 7.20% for the rolling 12 month period June 2019 to May 2020. This is a slight increase on the figure of 7.09% for April 2020.

Sickness absence – April 2020

The in-month sickness absence increased to 5.47% in April 2020. The rolling 12 month rate increased for the ninth consecutive month, to 4.11%.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 28.11% of sickness absence in April 2020, increasing from 27.90% in March 2020.

The RTW completion rate decreased to 51.54% in May 2019.

Essential Safety Training – May 2020

Performance has improved in 6 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 94.11% but remains below the stretch target for the fifth consecutive month.

Workforce Spend – May 2020

Agency spend fell by £0.16M, whilst bank spend decreased by £0.16M.

Recruitment – May 2020

1 of the 5 recruitment metrics reported (Shortlisting to Interview) deteriorated in May 2020. The time for Unconditional offer to Acceptance in May 2020 decreased and was just over 4 weeks.

DS noted there are 17 wellbeing buddies in the Trust and asked what the plan is to increase this number. SD advised that there are a number of friendly ear champions along with FTSU ambassadors, making up approximately 60 colleagues and recruitment is continuing. Nikki Hosty is working to co-ordinate these groups of colleagues who will support one culture of care as a wellbeing champion to each department/service/team. It was noted that NHSE/I are considering incorporating into the well-led framework that all trusts will have a designated well-being officer.

SD stated that following the Covid re-deployment of colleagues reflection is being given to whether colleagues should be matched to their existing/current department or consider the benefits of colleagues working across areas. SD requested that staff redeployment is discussed at the next Committee meeting.

SD advised that at 31 March 2019 sickness absence was under the 4% target which was the anticipated position for 31 March 2020. Over the last few months sickness absence peaked at approximately 12.5%. Covid now represents approximately 3% of overall absence. The national shielding programme is 'paused' from 1 August 2020 and conversations are progressing with shieldingcolleagues to facilitate their return to work. Sickness absence is expected to return to normal rates over the next 2 to 3 months.

DS questioned if the decrease in return to work submissions was symptomatic of Covid. SD advised that it is an ongoing issue and it was noted that work is ongoing to address this. SD confirmed that a 'people' related objective has been added to all manager appraisals to support one culture of care and achieve key workforce targets.

ACTION: Colleague deployment to be discussed at August 2020 meeting (SD).

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

25/20 **COVID HEALTH AND WELLBEING PLANS**

SD advised the Board of Directors agreed to continue to support and fund the 24/7 helpline. Debrief sessions have been established mainly for clinical colleagues with the first phase commencing with matrons in the Surgery Division. Listening events rolled out and Schwartz Rounds via Microsoft Teams have been hugely successful. The Trust's psychology team continue to be available for support and guidance. Next steps include a wellbeing buddy assigned to every team/service.

SD thanked staff side colleagues for their ongoing guidance and support and the joint learning that has helped develop the right responses. Learning from colleague feedback is that language and actions need to be carefully thought through as the impact can be very different for each individual.

The Committee expressed their thanks and support to the response plans.

Action: Provide Covid health and wellbeing plan activity outcomes to a future Committee meeting (SD)

OUTCOME: The Committee **RECEIVED** and **NOTED** and **SUPPORTED** the plans.

26/20 **EXIT INTERVIEW DATA**

MB presented data for the period 1 January 2020 – 30 June 2020. 248 colleagues had left the Trust during the period. 72 colleagues completed the leavers survey (29%).

The top reason for leaving is retirement age, with some peaks in voluntary resignation, lack of opportunities, promotion, and relocation.

55 colleagues said their managers had a conversation with them about their reason for leaving.

Overall colleague satisfaction working at the Trust is positive. Two areas did identify as requiring some focus: The Trust values my work and non-salary benefits.

Health and wellbeing question answers were overwhelmingly positive (84%).

42% of colleagues said they had felt unwell and were absent due to work related stress.

Equal opportunities is a positive overall response at 58%.

Appraisal results responses are overwhelmingly positive, 90% of colleagues had an appraisal in the last 12 months. 75% of the responses said their appraisal did help to set their objectives.

57.5% of colleagues said they would recommend the Trust as a place to work.

72.6% of colleagues said they would recommend the Trust for treatment.

62% of colleagues said they are staying within the NHS.

KH queried the leaver survey response rate. MB advised that the survey format has recently been refreshed to facilitate more simpler completion. The survey is now predominately a tick box approach with just one free text box at the end of the survey for users to add comments. As the survey is web based, colleagues are able to complete and submit after they have left the Trust. A section has been added to the termination form to prompt managers to remind colleagues and additionally the Business Intelligence team email the survey link to each colleague prior to leaving.

DS asked about survey results feedback. JE reported that there is reliance on managers to promote the survey but also that an early conversation be initiated by a manager to better understand the principal reasons for leaving in order to seek to address any issues and retain colleagues in employment.

Previously the line manager bulletin and general manager cascade has been a mechanism for promoting the survey. JE acknowledged additional activity is required to ensure conversations take place so as to improve the survey response rate. However, it was recognised that the aim is to maintain a dialogue with colleagues about their experience at work in order to deal with issues that may mean they become dissatisfied and ultimately leave their employment.

OUTCOME: The Committee **RECEIVED** and **NOTED** the data results and noted the revised approach.

27/20 **LEADERSHIP DEVELOPMENT PROGRAMME**

SD confirmed the online programme will launch on 31 July 2020.

The programme has several key modules including a launch module, WTGR, Management Essentials and Leading One Culture of Care elements.

Bespoke modules for Nursing and Midwifery, AHP and Medical Consultant will be available from September 2020.

The approach taken is to ensure learning is part of recovery of Covid. Colleagues can undertake the learning in their own time at a place to suit them. The programme is available to all colleagues, with all people managers being encouraged to undertake the programme.

SD advised the learning will be tracked via a log. KH asked about a mechanism for evaluation. Activity can be identified from the number of hits on the Intranet and leadership development will be a theme incorporated in the appraisal conversation. An option to

purchase a bolt on learning management system to enable tracking through ESR is being explored. Procurement timescale for this is 6 to 12 months.

Colleagues will be allowed one year to complete the programme. With a projection of 700 managers completing the programme, this would not have been possible via cohorted face to face learning. Colleague feedback has been very positive expressing strong support for the programme.

SD asked if Committee members would participate in recording a podcast about their particular leadership journey. PL and other directors had already signed up to this.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the Leadership Development Programme.

28/20 **ANY OTHER BUSINESS**

LS expressed thanks and gratitude to everyone concerned for the excellent communication in keeping colleagues updated, involved and engaged over the last few months, in particular the easy access to support and guidance.

PL stated he is proud to be Chair.

KH formally thanked everyone in Workforce and OD for their contribution and response to the Covid pandemic.

29/20 **DATE AND TIME OF NEXT MEETING:**

10 August 2020 via MS Teams.

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE
Held on Wednesday 10 August 2020, 1pm – 3pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
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)
Andrea McCourt	(AM)	Company Secretary
Helen Senior	(HS)	Staff Side Representative
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Nicola Hosty	(NH)	FTSU Guardian/ED&I Manager (for agenda item 39/20)
Adam Matthews	(AM)	Workforce Reconfiguration Lead (for agenda item 36/20)
Charlotte North	(CN)	Assistant Director of HR (for agenda item 34/20)
Jackie Robinson	(JR)	HR Business Partner (for agenda item 37/20)
Owen Williams	(OW)	Chief Executive

30/20 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

31/20 **APOLOGIES FOR ABSENCE:**

Helen Barker, Chief Operating Officer
Jason Eddleston, Deputy Director of Workforce and Organisational Development
Sharon Senior, Staff Side Representative

32/20 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

33/20 **MINUTES OF MEETING HELD ON 15 JULY 2020:**

The minutes of the Workforce Committee meeting held on 15 July 2020 were approved as a correct record.

34/20 **MATTERS ARISING**

Consultant Recruitment – Internet micro site

CN advised that prior to Covid, Magie an external company had been commissioned to develop the micro internet website. The build and background including updating starter packs, recording of podcasts and videos has been prepared by the Medical HR team however the actual internet site is paused as Magpie are currently furloughed.

CN reported on the success in the reduction in consultant vacancies. In April 2018 there were 95 consultant vacancies. Today's figure is 38 vacancies.

Currently there are 31 junior doctor vacancies. To supplement these vacancies an over

establishment of trust doctor vacancies has been created along with the introduction of junior clinical fellow vacancies in ED.

The Committee noted a Radiology Global Fellow Programme had been introduced in the Radiology Department. Following its success 3 further Radiology Global Fellows will join the Trust in November 2020.

The Committee commended Medical HR on their achievements particularly during the recent pressures.

Action: Provide update on Intranet Micro site at a future Committee meeting (CN)

35/20 **ACTION LOG**

The action log was reviewed and updated accordingly.

36/20 **COVID HEALTH & WELLBEING RISK ASSESSMENT**

AM confirmed the data sources to provide the triangulation of data comprised antibody testing, ESR, Health and wellbeing Risk Assessment, PCR testing and Roster.

- 6302 substantive colleagues included in this analysis.
- 5797 (92.0%) are at work, or are working from home.
- 106 colleagues were identified as being at an increased risk of severe COVID infection in the Health and Wellbeing Risk Assessment that were not assessed as part of the shielding group.
- 18.1% of antibody test results returned positive for BAME colleagues compared with 13.4% for White colleagues.
- Orthopaedics Directorate have the highest rate of antibodies detected in their test results at 39.5%. By comparison, Critical Care has just 9.9%.
- 5 colleagues did not have antibodies detected following a positive PCR test.
- Colleagues experiencing increased levels of anxiety are more likely to have had sickness absence episodes in the quarter 2 of 2020/21.

274 colleagues were identified as being at 'very high' or high' risk of severe COVID infection as part of the shielding assessment. The greatest concern is the 11 colleagues that have been identified as 'High Risk' from their responses to the Health and Wellbeing Risk Assessment' but no additional risk was identified as part of the shielding assessment.

Antibody testing has now been completed for 4502 substantive colleagues (71.4%). Antibodies were detected for 636 of those colleagues (14.1%). The results show BAME colleagues are more likely to have received a result showing antibodies detected. White females colleagues are the least likely group to have antibodies detected with just 13.0%.

The graph shows that colleagues that are experiencing increased level of anxiety are more likely to have had sickness absence episodes. 32.2% of colleagues in that group have had at least 1 sickness episode between 1 April 2020 and 30 June 2020, compared to 13.4% for those colleagues that have said they are not anxious.

DB queried if a deep statistical analysis of data had been undertaken. AM advised conclusions were compiled from comparisons of data.

OW shared with the Committee antibody testing data of colleagues' residence and ethnicity. There is a view that overlaying different levels of workforce data can potentially provide a route map as opposed to symptomatic testing alone.

EA noted the high incidence of positive antibody results along with significant Covid related

sickness absence in Ward 20. EA expressed a view that these results are not unexpected and pointed out the benefits of learning from softer intelligence such as feedback from experienced managers particularly when triangulated data isn't available, enabling a quicker response.

SD reported the results from the analysis and triangulation of data corroborated the health and wellbeing risk assessment had been critical to ensuring colleagues have the appropriate interventions in place. SD confirmed there is mechanism within the external mental health service for review and evaluation. Risk assessment leads would connect with Occupational Health to review and assess outcomes in terms of colleague physical issues.

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

37/20 **STAFF RE-DEPLOYMENT PLANS**

JR presented the approach and activities in response to workforce escalation, reset and stabilisation. EA wished to thank all involved in the extensive work undertaken over the recent months. She acknowledged the Trust now has a robust skills matrix for the future particularly beneficial over the winter months and also the importance on colleagues maintaining new skills through ongoing CPD. EA considered a key element to success was through local conversations and strong relationships between line manager and indviduals.

CP expressed some concern in terms of colleagues resetting in response to the restarting of elective procedures. EA advised the Clinical Workforce Group will continue to meet to map colleagues to respond to service needs and acknowledged the uncertainty at this time.

OW asked about systems for tracking multiple moves of colleagues. JR advised that workforce models in Roster are able to report accurately on where colleagues are working at any given point. DH saw opportunity for further rotational schemes perhaps to support the future transformation work.

CN had a view that asking colleagues to cancel annual leave rather than enforcing would have resulted more positively. OW felt there were alternatives to cancelling annual leave that were not explored and this should be noted for the future.

KH commented on the learning and the positive outcomes as a result of Covid-19. The Committee noted examples of how colleagues had supported each other. JR felt it had been a very emotional time.

KH expressed congratulations to all.

OUTCOME: The Committee **RECEIVED** and **NOTED** and **SUPPORTED** the plans.

38/20 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JUNE 2020**

MB presented the report.

Summary

Performance on workforce metrics continues to be high although the Workforce domain decreased to 76.1% in July 2020. This is now 15 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 d and Covid-19.

Workforce – June 2020

The Staff in Post increased by 11.07 FTE, which, due, in part, to 30.34 FTE new starters in June 2020. This led to a decrease of 0.17 FTE vacancies.

Turnover decreased to 6.86% for the rolling 12 month period July 2019 to June 2020. This is a slight decrease on the figure of 7.20% for May 2020.

Sickness absence – May 2020

The in-month sickness absence decreased to 4.22% in May 2020. The rolling 12 month rate increased for the tenth consecutive time in 19 months, to 4.22%.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 35.13% of sickness absence in May 2020, increasing from 28.11% in April 2020. The RTW completion rate increased to 56.86% in May 2020.

Essential Safety Training – June 2020

Performance has improved in 6 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 94.24% but remains below the stretch target for the sixth consecutive month.

Workforce Spend – June 2020

Agency spend increased by £0.19M, whilst bank spend increased by £0.12M.

Recruitment – June 2020

2 of the 5 recruitment metrics reported (Pre employment to unconditional offer, and Unconditional offer to acceptance) deteriorated in June 2020. The time for Unconditional offer to Acceptance in June 2020 decreased and was just over 5 weeks.

KH asked about the response rate of return to work interviews. SD confirmed the ongoing work to increase rates.

The Committee noted the improvement in sickness levels. SD advised that CHFT benchmarks well against other Trusts but cautioned about sickness absence impact during school holidays.

DS asked what the challenges are in the compliance of role specific training. Generally role specific modules take longer to complete and is face to face training. Some of the modules are being converted to virtual training to increase participation.

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

39/20 **FREEDOM TO SPEAK UP ANNUAL REPORT**

NH perceives the increase in reporting of concerns suggests that colleagues are gaining trust and confidence in the FTSU process. Nine concerns were reported in 2018. This increased to 67 in 2019 and at the end of June 2020, 52 concerns have been reported. Increased focus on colleague accountability and a culture of 'your voice matters' is making a real difference in the Trust.

The number of FTSU ambassadors has increased. Colleagues can choose to have a conversation should they not wish to use the FTSU Portal.

During the pandemic primary themes of concern emerged; management relationships, lack of PPE, colleagues feeling like commodities. This crisis is an opportunity to listen to colleagues' voices for learning and improvement. All FTSU concerns reported during Covid have been captured and communicated to the Incident Management Team. This feedback should support improvements in 'resetting services' and any preparations should there be a second wave.

Future areas of focus will be to increase volunteer FTSU ambassadors, ensure that learning from FTSU is incorporated into development of patient safety processes and continue to increase visibility of speaking up channels. Analysis of NGO case studies and recommendations for best practice to be examined within the FTSU team and recommendations for action will be taken as a result of these discussions.

DS asked if ambassador colleagues are volunteers from across all divisions. NH acknowledged this was the case and could be strengthened further by increasing the numbers. KH asked if special training is required. NH explained that buddying up, monthly meetings and quarterly check-ins provides support to volunteers and enhances their skills.

OW stated the FTSU process creates an opportunity for colleagues to raise concerns where one culture of care/4pillars is not being adhered to.

DS asked what support is available in terms of complex concerns particularly during the pandemic. At the beginning of the pandemic the NGO provided free access to employer systems programmes. NH advised she has 'go to' people outside of the organisation for her own wellbeing along with internal Executive level support and Jason Eddleston the FTSU Champion.

DS asked if concerns are fed into the IMT regularly and if this will continue. NH confirmed concerns will continue to be escalated as required.

KH commended NH on an excellent piece of work.

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

40/20 **ANY OTHER BUSINESS**

The Committee noted the 2020 NHS Staff Survey is to be launched the second week in September and will run for the full period. Some Covid-19 questions will be incorporated. Focus will be on quality of response.

SD advised a response to the NHS People plan is being developed and will be submitted to the Board of Directors in September 2020. The documents will be uploaded to The Cupboard and will be a subject for a deep dive at a future Committee meeting.

Board Assurance Framework to be added to the workplan

41/20 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Well Being Risk Assessment
Redeployment plans
Positive elements of Workforce Performance Report
FTSU

42/20 **EVALUATION OF MEETING**

What went well: Colleagues outside of WOD involved in the meeting to challenge workforce activities.

43/20 **DATE AND TIME OF NEXT MEETING:**

19 October 2020
Hot House: Skill Mixes & Hybrid Roles, 1pm-3pm, DR1&3, Learning Centre, HRI
Review Quality & Performance Report – Workforce, 3pm – 4pm, DR2, Learning Centre, HRI

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Monday 29 June 2020 - 8.30 – 9.30 pm
Microsoft Teams

PRESENT

Denise Sterling – Chair (DS)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director

IN ATTENDANCE

Anna Basford (AB)	Director of Transformation and Partnerships
Andrea McCourt (AM)	Company Secretary
Linda Cordingley (LC)	Minutes

37/20 APOLOGIES FOR ABSENCE

There were no apologies for absence.

38/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 5 June 2020 were **APPROVED**.

Knowledge Portal – AN had shared this with NEDs so they were all now aware of the level of detail available from the system.

AN confirmed that he had received copy of the report recently presented to the Quality & Workforce Committee that provided information related to the outcomes and mortality of patients treated in the hospital with Covid-19.

39/20 PROVISION OF FACE MASKS TO PARTNERS

AB gave an update of the decision made by the Outer Core Group on 15 June 2020 regarding the proposal to provide face masks to partners. It was noted that the national guidance to wear masks/face coverings had been implemented across the Trust on 15 June 2020. Masks were therefore being supplied to patients, visitors and staff entering our hospitals. A proposal had been considered by the Inner Core Group to provide masks for partner organisations and contractors, to which there had been mixed views, therefore this had been escalated to the Outer Core Group. The Outer Core Group considered the proposal and recognised that the safety of patients and colleagues was paramount, whilst acknowledging the health and safety responsibilities of external organisations. The Trust had an adequate supply of PPE therefore it was agreed that the Trust should supply face masks on the basis that should our position change we may have to prioritise supply to high risk areas. It was recognised that this would mitigate the risk of individuals coming on site without appropriate PPE.

The Committee **SUPPORTED** the decision made by the Outer Core Group.

40/20 PROPOSAL TO RESTART FERTILITY SERVICES

AB gave an overview of the proposal to restart fertility services, which had been suspended at the start of the Covid-19 pandemic. There had been a National announcement in May 2020 that fertility services could restart if centres were able to meet the relevant safety requirements set out for licensed organisations – ie Leeds and Manchester Care. This had prompted our internal service to put forward a proposal to the Inner Core Group to restart on the basis of the locally managed care element, which they had advised they could do without requiring additional staffing and with an adequate supply of PPE. The Inner Core Group had reservations on the basis that restart work across the whole Trust on which services and at what level had not yet concluded and staff may be required elsewhere in the organisation.

The Outer Core Group reviewed the proposal and made a request to the Inner Core Group to clarify the staffing levels in the fertility service and confirm whether or not they were required elsewhere in the Trust. Subject to confirmation that the staff were not required in other parts of the Trust, then the service could restart. AB advised that the Trust had responded to MPs and patients who had contacted the Trust. It was noted that the restart date had not yet been confirmed but it was likely to happen quickly once the Inner Core Group had addressed the staffing issue.

The Committee **SUPPORTED** the decision made by the Outer Core Group.

41/20 TEMPORARY CONSOLIDATION OF AMBULATORY CARE SERVICE

AB advised that a response was still awaited from the Inner Core Group. It was noted that the bed modelling and plan were still being considered.

42/20 OUTER CORE REGISTER OF DECISIONS

The Register of Decisions from the Outer Core was received, and the decisions made since the last meeting were reviewed by members. This register would be updated following Outer Core Group meetings.

Following the presentation to the June Board of Directors' meeting, the Outer Core Group felt that it had a role to provide a subjective view on the developing plans to ensure robust EQIA and QIA assessments and clarity of communication were in place. It was noted that there would be an update on current progress on the stabilisation and reset work at the Board of Directors' meeting on 2 July 2020. A further statement would be added to the Register to close off this action.

Calderdale and Huddersfield NHS Foundation Trust

43/20 INNER/OUTER CORE GROUPS

AB advised the Oversight Committee that due to the work Owen Williams was undertaking at National level on health inequalities, the following changes had been made to the working arrangements from 25 June 2020:

Ellen Armistead/Jason Eddleston would transfer from the Inner Core Group to the Outer Core Group. Suzanne Dunkley would transfer from the Outer Core Group to the Inner Core Group.

Memberships were therefore:

Outer Core Group – Ellen Armistead, Gary Boothby, Anna Basford, Jason Eddleston

Inner Core Group – Helen Barker, David Birkenhead, Suzanne Dunkley, Mandy Griffin, Stuart Sugarman

44/20 DATE AND TIME OF NEXT MEETING

The next three meetings would be scheduled in due course via Microsoft Teams.

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Monday 20 July 2020 - 8.00 – 9.00 pm
Microsoft Teams

PRESENT

Denise Sterling – Chair (DS)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director

IN ATTENDANCE

Anna Basford (AB)	Director of Transformation and Partnerships
Andrea McCourt (AM)	Company Secretary
Linda Cordingley (LC)	Minutes

45/20 APOLOGIES FOR ABSENCE

AN gave his apologies for absence.

46/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 29 June 2020 were **APPROVED**.

47/20 TEMPORARY CONSOLIDATION OF AMBULATORY CARE SERVICE

AB advised that it has previously been agreed to consolidate the Ambulatory Care Service on the Huddersfield site in order to provide additional bed space at CRH during the pandemic period. The staff from the CRH service had been redeployed to other areas of the Trust during this period. The Outer Core Group had been provided with an update that the Inner Core Group were in a position to reinstate the service at CRH and could accommodate this in the overall bed plan. The Outer Core Group agreed in principle but sought assurance that the reopening at CRH would not negatively impact on other areas of service in terms of staffing and that effective communication with patients was put in place. The Inner Core Group provided a further update recommending that the CRH Unit reopened on 20 July 2020 and provided assurance that appropriate rotas and a communication plan was in place to inform patients. The CRH Unit would re-open to new patients only. The CCGs had contacted GPs in terms of new referrals. Patients who had previously attended at Huddersfield and may need repeat treatment would continue to attend at Huddersfield. The Outer Core Group had confirmed that sufficient assurance had now been provided.

DS referred to the earlier discussion when alternative provision on Ward 1 at CRH was being considered should there be a further surge. AB advised that initially the service had been suspended to provide flexibility to redeploy staff to support other areas in the Trust during the pandemic crisis and provide more areas for zoning of bed areas. In reopening the service at CRH this bed capacity was no longer required. However if there was a further surge the Unit at CRH would remain open, moving to Ward 1D, which was currently a vacant site. DS said it was a positive

outcome for patients to continue to receive their care, part way through a course of treatment, at Huddersfield.

The Committee **SUPPORTED** the decision to return to a two-site service.

48/20 OUTER CORE REGISTER OF DECISIONS

The Register of Decisions from the Outer Core was received, and the decisions made since the last meeting were reviewed by members. This register would be updated following Outer Core Group meetings.

Consolidation of Children's Acute Services on the Calderdale Site – AB agreed to follow up on the position regarding the Outer Core Group's request to seek CQC advice on the proposed phased plan.

Bowel Cancer Screening Endoscopy – AB advised that this service was being providing by Trust staff working in the Independent Sector hospitals.

Incident Management Team – AB advised that the Team continued to meet on a daily basis. A workshop had been organised to identify priorities going forward and the timing of resuming normal executive governance arrangements. This would also need to link into the Board of Directors' discussion on business better than usual.

Covid-19 Oversight Committee – as the Inner Core Group were managing operational issues and there was limited need for recourse to the Outer Core Group for decision-making, it was agreed to continue to meet only as deemed necessary. It was noted that the full reset operational plan was anticipated by the end of August, which would be considered by the Outer Core Group.

49/20 DATE AND TIME OF NEXT MEETING

The next meeting was scheduled for Friday 14 August 2020 at 8.30 am.

ORGAN DONATION ENGAGEMENT GROUP MEETING
WEDNESDAY 15 JULY, 2020
ICU SEMINAR ROOM, CALDERDALE ROYAL HOSPITAL

MINUTES

Present: Philip Lewer (Chair)
Paul Knight, Clinical Lead, Organ Donation
Jayne Greenhalgh, Specialist Nurse, Organ Donation
Caroline Winkley, Sister, ICU
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
Nicki Schofield, Staff Nurse, ICU
Kim Maloney, ODP, CHFT
Jenny Taylor, Finance
Annette Bell, Governor
Rebecca Johnstone, Admin Team Leader, Operating Services and Critical Care

Apologies: Caroline Wright, Communications Team

Minutes of the Last Meeting

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

Karen Piotr agreed to attend future CHFT ODC meetings as a representative from the ambassadors team.

Donation Activity

Paul reported that he sent out an email stating that, on a personal level, he was enormously pleased about how everyone has pulled together during the difficult last few months to achieve referrals where needed and that this reflects in the report. There was one case where brain stem death testing had not taken place, Paul has looked into this case and talked it through with the appropriate clinicians re lessons learnt.

Paul reported that one of the things proving difficult throughout the region is predicting time to asystole in the DCD Donor. It is a broader issue than we can deal with in our local group. Jayne stated that this is a national problem and always something NHSBT do monitor.

Malcolm stated that we are pleased with the results of the NHSBT report for CHFT – 100 per cent referrals and 100 per cent SNOD presence. He would like to ensure our congratulations to the team are recorded in this meeting. Jayne will make a poster for the ICU coffee room. Sarah passed on huge thanks to the team and said that, despite everything going on at the moment, we are still keeping organ donation in mind and performing well as a Trust.

Missed Opportunities and Action Taken

Paul stated that he is not aware of any missed opportunities since our last meeting.

Legislation Change

Jayne and Sarah reported that legislation changes are going live in the next few days. 100 per cent of the SNOD team are trained. We will go live in the Yorkshire region on 20 July. Jayne has reassured staff that they are not going to see a difference on the front line, referrals should be made in exactly the same timely way. The law change may be used for families who have not talked about donation and do not know their loved ones wishes, so it is just another tool for different conversations. It remains best practice not to pre-approach for donation without SNOD presence.

Malcolm wondered if the legislation changes have been kept low profile as a national campaign doesn't seem to have happened. Philip will speak to Caroline in Communications to see if anything has been arranged. He also said that we still have twice weekly Covid-19 newsletters which are sent to 6,000 members of staff and we could use this opportunity with advice and guidance from Caroline.

Donor Recognition Funding and Finance

Plans for mounting Jovial Man onto a plinth have been put on hold, as the sculptor's brother lives in the South West and is currently shielding. Nothing is likely to be planned for this before November, however Caroline has been in touch with him and he is happy for us to share the story in the media during Organ Donation Week.

Gary asked where this would be placed and whether it would need to be moved during reconfiguration. Paul reported it is to go between the shop and the chapel at HRI, near to the organ donation memorial.

The cost of putting the sculpture onto a plinth is £2,000 and this makes use of some of our funding in the bank. Jenny said that after that there will be £792 carried forward from last year. Sarah said that the letter for this financial year is currently with their admin team and should be with us soon and she reported we have a total of £13,768, which is to be split between ICU and Theatres. Paul said he is open to suggestions from the group for use of any other funds that may become available. Jenny will send an update after the meeting.

Promotional Activity/Organ Donation Week

This has been brought forward a week to week commencing 7th Sept. This year we are looking at virtual events. Sarah reported a national call to the Comms teams to see what the theme is going to be. One suggestion is 'Yorkshire Landmarks' with photographs of SNOD teams outside a local landmark. We need to start planning as soon as possible. Any ideas gratefully received.

Malcolm said he is liaising with Bradford Council with regard to having several buildings in Bradford floodlit in pink. Paul suggested the Piece Hall may be a good place for CHFT. Jayne suggested we get in touch with Caroline in Comms to pull all this together.

Other suggestions from Malcolm were to fly a flag for organ donation and to identify a donor family. Sarah is in contact with someone about flags for organ donation week and will let us know the outcome.

Gary will contact Caroline regarding a CHFT colleague who donated a kidney as an act of kindness.

Gary revealed he had a liver transplant 24 years ago.

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

Paul stated that when our monitors power down they make a 'happy little jingle', which can be inappropriate at withdrawal of treatment. He has arranged with the manufacturers to remove this jingle, so hopefully this will be dealt with.

Feedback to Trust Board

Philip reported that he uses every opportunity he can to formally feedback at Board meetings. Annette is a governor and feeds back to the council of governors.

Policies and Guidelines

Paul will chase up getting the new guidelines on the website.

Review of Governance Structure/ Terms of Reference

Gary said that he is more than happy to promote.

YODELS

Jayne reported that the first Yodels on tour in Bradford in May had to be postponed due to Covid-19. We are hoping to go to Pinderfields in October, but not sure yet whether this will be possible. Jayne suggested that training could be done on Zoom.

Any Other Business

Communication between Trusts - Malcolm reported that he has trialled a meeting on Zoom as a better way of communicating between different hospitals. He said it was a very useful session about how we could work more closely together and share knowledge. Philip is in full support of this.

Regional Chair – NHSBT are looking to have a regional chair in post. Sarah suggested asking chairs currently in the region as this has to be a current chair.

Transplant Games, 2021 - Caroline Winkley reported that the British Transplant Games are coming to Leeds on 3 to 6 August, 2021. She said this is a massive opportunity to promote things in the area and suggested we get local athletes in for promotion. Sarah said this is an opportunity to get all the different committees together at the same time. Caroline will be the Committee's lead on this for disseminating information.

Unfortunately, the World Games in Texas next year have been cancelled.

Date and Time of Next Meeting

Wednesday 13 January, 2021 – 10.30 am – via Teams.
Wednesday 7 July, 2021 – 10.30 am – via Teams.

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 3:30 PM ON THURSDAY 9 JULY 2020 VIA MICROSOFT TEAMS

PRESENT:

Philip Lewer	Chair

Public Elected Governors

Lynn Moore	Public Elected - North and Central Halifax
John Gledhill	Public Elected – Lindley and the Valleys
Christine Mills	Public Elected - Huddersfield Central
Annette Bell	Public elected – East Halifax and Bradford
Stephen Baines	Public elected – Skircoat and Lower Calder Valley – Lead Governor
Chris Owen	Public Elected – South Kirklees
Alison Schofield	Public Elected – North and Central Halifax
John Richardson	Public Elected – South Huddersfield

Staff Elected Governors

Linzi Smith	Staff Elected – Management / Admin / Clerical
Sian Grbin	Staff Elected – Nursing and Midwifery

Appointed Governors

Cllr Lesley Warner	Kirklees Metropolitan Council
Helen Hunter	Healthwatch Kirklees and Calderdale
Jayne Taylor	Calderdale and Huddersfield Solutions Ltd (CHS)
Cllr Megan Swift	Calderdale Metropolitan Council

IN ATTENDANCE:

Alastair Graham	Non Executive Director
Andy Nelson	Non Executive Director
Denise Sterling	Non-Executive Director
Gary Boothby	Director of Finance
Andrea Dauris	Associate Director of Nursing for Quality & Safety
Peter Keogh	Assistant Director of Performance
Andrea McCourt	Company Secretary
Jackie Ryden	Corporate Governance Manager (minutes)

16/20 APOLOGIES FOR ABSENCE

Veronica Woollin	Public Elected - North Kirklees
Sheila Taylor	Public Elected – Huddersfield Central
Brian Richardson	Public Elected – South Kirklees
Paul Butterworth	Public Elected – East Halifax and Bradford
Dianne Hughes	Public Elected – North Kirklees
Peter Bamber	Staff Elected – Doctors and Dentists
Rosemary Hoggart	Staff Elected – Nurses and Midwives
Prof Felicity Astin	University of Huddersfield
Chris Reeve	Locala
Owen Williams	Chief Executive

17/20 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors and staff presenting papers to the meeting.

It was noted that the Council of Governors meeting scheduled for 23 April 2020 had been cancelled due to the Covid-19 pandemic.

18/20 DECLARATIONS OF INTEREST

The Chair reminded the Council of Governors and staff colleagues to declare their interest at any point in the agenda.

19/20 MINUTES OF THE LAST MEETING HELD ON 23 JANUARY 2020

The minutes of the previous meeting held on 23 January 2020 were approved as a correct record.

OUTCOME: The minutes of the previous meeting held on 23 January 2020 were **APPROVED** as a correct record.

20/20 MATTERS ARISING / ACTION LOG

The action log was reviewed and updates were noted.

OUTCOME: The Council of Governors **NOTED** the updates to the action log.

21/20 CHFT COVID-19 RESPONSE

The Assistant Director of Performance presented an update on the Trust's response to Covid-19 including the current position on number of tests carried out for Covid-19, the number of in-patients, deaths and discharges and staff absence. The presentation also incorporated the key principles of stabilisation and reset planning, capacity constraints and work being undertaken, the cancer position, health and well-being assessments and the key risks.

The Chair asked if an update could be provided on outpatients as this had been raised at the Private meeting prior to the public meeting. The Assistant Director of Performance advised that he is the Chair of the performance meeting for the outpatient recovery workstream. There is a significant backlog as treatments have been halted. In general, a great deal of validation work is being undertaken in all specialties and services currently. Meetings have been held with all clinical directors to review plans to prioritise appointments and the types of appointments to be offered. Outpatient capacity is currently at 30%, which is a significant reduction. Regular meetings are being held with all services and divisions and considerable work is being done to ensure the Trust gets back on track with assessments and appointments, although the new 'normal' will be through virtual means rather and face to face.

The Chair asked if the Assistant Director of Performance could explain how the Trust is working with GPs to prioritise patients based on clinical need rather than the time a

patient has been waiting. The Assistant Director of Performance explained that guidelines have been received on prioritisation from the elective perspective for inpatient and day cases, and that the Medical Director is leading a workstream looking at prioritisation for outpatients.

SG asked if guidance had been received both for colleagues who have returned to work after shielding or self-isolating and for colleagues who are pregnant. The Assistant Director of Performance was not able to provide this detail but the Chair undertook to find out this information.
Action: Chair to provide details on guidance for colleagues who are pregnant.

The Director of Finance advised that he has been leading a group of shielding staff and keeping in regular contact with them. The message throughout has been that the Trust will not put staff at risk. He added that a great deal of work has been undertaken on a risk assessment basis with individual risk assessments carried out on all colleagues, and, where necessary, different roles will be identified for individuals.

CHFT has remained open for two-week wait referrals for cancer and has continued with some urgent outpatient activity and high risk cancer surgery and some diagnostics. CHFT is now seeing and treating all cancer and urgent surgical patients in a super green elective area. During the outbreak Emergency Department attendances reduced to approximately 25% but these are now back up to 100%. There are two segregated Emergency Departments at both sites. Prioritisation of patients and management of risk around any harm to patients due to stopping elective activity is key.

SB asked if data is available on the number of retired staff who have returned to CHFT and whether it would be possible to give them a vote of thanks. The Chair will find out the information from the Director of Workforce and Organisational Development and will send them a letter on behalf of the governors. Linzi Smith advised that she has access to this information and will share with the governors following the meeting.
Action: PL/SB to send a letter of thanks on behalf of the governors to the retired staff who have returned to CHFT.

CHFT is performing well on Cancer compared to other organisations within West Yorkshire.

A health and well-being risk assessment has been circulated to all colleagues and over 1,500 responses have been received. A number of themes have been identified and are being addressed.

OUTCOME: The Council of Governors **NOTED** the update on the Trust's Response to Covid-19.

22/20 PERFORMANCE AND STRATEGY

a. Performance Report for May 2020

The Assistant Director of Performance presented an update on the Trust's performance position for the end of March 2020, given that the April Council of

Governors meeting had been cancelled due to Covid-19, and the position at the end of May 2020. The Trust performed very well for 2019/20. There were a significant number of domains which had a 'green' rating and there were no domains over the year rated as 'red'.

Although the Trust missed the Emergency Care 4-hour standard during 2019/2020, it benchmarked extremely well nationally when its two key metrics (Emergency Care and 62 day Cancer) were considered together. It was placed third out of 115 acute organisations nationally. The Trust had been due to get back on track for diagnostic targets at the end of March, but this was not achieved due to the pandemic.

The Assistant Director of Performance advised that the 18 week elective care standard would normally have been included in the three key performance indicators but CHFT is one of 12 pilot organisations looking at a new elective care standard (average waits for patients as opposed to patients who have waited 18 weeks). Prior to the pandemic CHFT was at an 8.8 week average standard for that but this has increased due to the pandemic and the necessity to stop surgery. The pilot, which started in August 2019, will continue as there was not enough evidence for change from the August to the year end position.

The Assistant Director of Performance explained that the Trust Integrated Performance Report (IPR) will change during 2020/2021 as it will need to be more focused on patient outcomes. Several meetings have been held to determine the key performance indicators and this work is ongoing. However, a number of these changes have been included in the May report, and the focus on patient outcome based key performance indicators will open a debate on performance in a number of different areas. The focus on readmissions is in one of the key indicators in the Care Quality Commission (CQC) Insight report.

Trust performance for May 2020 was 72.8%. A number of indicators are still being affected adversely by the Covid-19 situation including sickness, diagnostics 6 week waits, Appointment Slot Issues (ASIs) and 52 week waits.

More positively the Emergency Care 4 hour standard was achieved for the whole of May.

Councillor Warner raised a concern regarding the plan for Business Better Than Usual in relation to staff shortages. The Director of Finance explained that NHS England/Improvement (NHS E/I) requires CHFT to submit plans for those patients who require treatment. There is a recognition that in order to keep patients safe, there is an additional financial impact and additional staffing requirements. The responses submitted by the Trust have been cautious, taking into account the experience and difficulties faced by colleagues over the last months. It is important to find the right balance to care for patients whilst being mindful of what is being asked of colleagues.

OUTCOME: The Council of Governors **NOTED** the performance report for May 2020.

b) Financial Position and Forecast – Month 2

The Director of Finance summarised the key points from the financial year ending 31 March 2020 and the Month 2 position at the end of May 2020. GB advised that CHFT delivered a surplus for the last financial year, 2019/20 for the first time in many years. CHFT delivered the plan that had been set and therefore received a funding of £10m.

The Trust had been in the process of developing a plan for the 2020/21 financial year which after receipt of the £27.48m financial improvement trajectory funding, would have resulted in a breakeven position, although it was noted that this plan would have been challenging. All plans were put on hold due to the pandemic and since then the whole architecture of the financial regime has changed. Income flows are now largely on a block basis, designed to simplify some of the transactions within finance. It was noted there would be no cost improvement target required for the first four months of the year. The cash position at the end of month 2 shows £55.19m in the bank compared to last year when all months ended with £1.7m in the bank.

All spend incurred on Covid-19 is funded retrospectively by means an application by the Trust for top up funds. Year to date the position is at break even after the receipt of £5.8m of retrospective top up funding for monies spent for Covid-19. The Trust spent £6.62m of revenue specifically on dealing with Covid, including additional pay, Personal Protective Equipment (PPE), consumables. Without this, the Trust would have underspent by approximately £1m, which is due to less elective activity taking place.

The regime for the rest of the financial year has not yet been confirmed but it is assumed the Trust will break-even. Work has been undertaken to look at 2020/21 activity and financial modelling to assess how much more money would be required in order to do more activity.

LS asked if the £6.8m spent on Covid includes capital, for items such as laptops, and the Director of Finance confirmed that the £6.8m is revenue but approximately £1m has also been received in terms of capital. He added that NHS E/I has been very supportive.

OUTCOME: The Council of Governors **NOTED** the 2019/2020 End of Year Financial Summary for 2019/20 and the Month 2 Financial Summary for 2020/21

23/20 QUALITY ACCOUNTS

The Associate Director of Nursing for Quality & Safety gave a presentation and shared a paper to advise on changes to the process for Quality Accounts for 2019/2020 and share the progress made with the quality priorities chosen by the governors in 2019/20. The quality priorities for 2020/21 were also included in the paper.

The Associate Director of Nursing for Quality & Safety advised that the Trust improved on all three priorities chosen for 2019/20 as follows:

<u>Priority One – Emergency Department (Safety)</u>

- Trusted assessment

- Trusted assessor
- Home First Team
- Standardised MDT meetings
- Enhanced reablement
- Introduction of the non-weight bearing pathway
- Community care discharge to assess beds
- In the Emergency Department there has been a gradual improvement in the reduction of beds used for long stay patients since April 2018 and this ambition has been sustained.

Priority Two – Deteriorating Patients (Effectiveness)

- In line with NEWS2 the escalation policy was revised as part of the overall Adult Physiological Observation policy.
- In-hours and out of hours escalation processes are in place based on the NEWS
- Digital prompts within Nervecentre encourage staff to consider and perform sepsis screening tests for these patients

Priority Three – Mental Health (Experience)

- Early intervention from the mental health liaison team
- Comprehensive departmental standard operating procedure
- Designated safe environment
- Ongoing risk assessments
- Clear lines of escalation
- Introduction of a rapid investigative tool.

OUTCOME: The Council of Governors **NOTED** the changes to the 2019/20 Quality Account process and timeline, **NOTED** the progress made with the 2019/2020 Quality Account priorities and **NOTED** the agreed Quality Account priorities chosen by governors and members for 2020/21.

UPDATE FROM COUNCIL OF GOVERNORS SUB-COMMITTEE

24/20 Nominations and Remuneration Committee

The Chair advised that the Nominations and Remuneration Committee (Council of Governors) approved the process for the annual appraisal of the Non-Executive Directors and Chair. A meeting had been scheduled for 25 March 2020 but was cancelled due to the pandemic. The meeting was therefore held virtually and approval confirmed by email. The appraisal process will involve the Lead Governor.

OUTCOME: The Council of Governors **NOTED** the approval of the process for the annual appraisal of Non-Executive Directors and Chair by the Nominations and Remuneration Committee.

GOVERNANCE

25/20 Update from Lead Governor/Chair

Stephen Baines had provided an update to governors in the private meeting held immediately before the public meeting but asked that governors email him directly if they had any further questions.

SB formally thanked the Non-Executive Directors and Chair on behalf of the Governors for their hard work and commitment over and above their contracted hours. He added that the challenge the Non-Executive Directors provide is much appreciated, and that Denise Sterling and Peter Wilkinson, as relatively new Non-Executive Directors have 'hit the ground running'.

OUTCOME: The Council of Governors **NOTED** the Update from the Lead Governor and Chair.

26/20 COMPANY SECRETARY'S REPORT

Changes to Governance Arrangements
The Company Secretary presented a paper to outline the changed governance arrangements made by the Trust in relation to the Board and governors as a result of the Trust response to the Covid-19 pandemic.

The Company Secretary advised that in line with national guidance, the Annual General Meeting scheduled for 15 July 2020 had been deferred. A provisional date has now been agreed for Wednesday 7 October 2020 from 5-6.30pm. This will be a virtual meeting rather than a meeting held in public, for the safety of the public. Arrangements will be confirmed in due course on the Trust website to advise how members of the public can ask questions.

OUTCOME: The Council of Governors **NOTED** the changes to the governance arrangements in response to Covid-19, **NOTED** the position regarding governor extensions and lead governor arrangements for 2020/21, and **NOTED** the changes made to Board and Committee meetings the revised date of the Annual General Meeting.

27/20 NON-EXECUTIVE DIRECTORS

a. Review of NED Tenure September 2020

The Company Secretary presented a paper to advise on Non-Executive Director tenures which are ending during 2020 and the process for review of appointments.

Alastair Graham declared an interest for agenda item 13a Review of NED tenure.

A meeting of the Nominations and Remuneration Committee will be held on 8 September 2020 and the outcome of this will be presented to the Council of Governors meeting on 22 October 2020. The Lead Governor will be co-ordinating the response.

OUTCOME: The Council of Governors **NOTED** the upcoming tenures of two Non-Executive Director for 2020 and the process for review of these.

b. Feedback from Non-Executive Directors in attendance

Alastair Graham, Andy Nelson and Denise Sterling gave a brief introduction including their background and their current focus in their role as Non-Executive Directors.

Governors were also invited to forward any questions to the Non-Executive Directors outside of the meeting.

Alastair Graham highlighted the following:

- AG is Chair of Calderdale and Huddersfield Solutions Limited (CHS). CHS have reported a successful financial year for 2019-20, have met most of their key performance indicators and have made a donation of £120k to Trust Charitable Funds for patient care.
- The contract for waste disposal has been changed to a new provider and will deliver a saving of £150k per year as well as a better contract.
- Good working relations between CHS and CHFT during the pandemic.
- AG also sits on the Research and Innovation Committee. CHFT is one of the Trusts that has been involved in the national project for potential treatments for Covid-19 and was one of the Trusts who recruited the largest number of patients to the trial for the successful use of Dexamethasone.
- AG sits on the Transformation Programme Board where it has just been agreed to commence some enabling works to go ahead in advance of the reconfiguration work.

LS asked if the CHS staff are able to access the health and well-being service being offered to colleagues, and AG confirmed this was the case. They have been given paper copies of the health and well-being survey and access to a desk top computer or IPad and their results included in the survey.

Andy Nelson highlighted the following:

- As Chair of the Audit and Risk Committee at the meeting held in June 2020, the Committee approved the annual report and accounts; the Trust reported a stronger financial position than the previous year, in addition to an improvement on the previous year for internal audit. Risk management has focused on activity related to Covid-19 risks, with Personal Protective Equipment (PPE) being the top risk and concern. It was noted, however, that CHFT had not had an issue with PPE throughout the pandemic period.
- AN also sits on the Transformation Programme Board and Covid Oversight Committee.
- AN also attends The Health Informatics Service Board. He advised that CHFT is one of the leading Trusts in the country in the use of technology and this has continued through the pandemic. The strategic direction and investment plan for the Digital Strategy was approved by the CHFT Board at its meeting on 2 July 2020.
- AN also chairs the Resilience and Security Management Group which has been paused since the start of the pandemic.

Denise Sterling highlighted the following:

- DS chairs the Quality Committee which has continued to meet throughout the pandemic but was combined with the Workforce Committee with streamlined agendas to cover the most important issues. From a quality perspective focus was on Covid-19 related issues, the Covid-19risk register, mortality rates, serious incidents and high-level risks. From a workforce perspective focus has been on the health and well-being offer and strategy going forwards.
- DS also chairs the Covid Oversight Committee, an interim committee that was set up for the duration of the pandemic for the Non-Executive Directors to provide scrutiny and oversight of decision making by the Executive team. The Committee

has met on five occasions to date and were able to support all of the decisions that had been made by the outer core team.
- DS has also been involved in the recent recruitment of consultants and two associate director positions, using technology to facilitate this.

The Chair expressed his full support for the work undertaken by the Non-Executive Directors. The Director of Finance echoed this sentiment and added that the Non-Executive Directors have continued to challenge the Executive Directors and have been working differently with more frequent contact throughout the pandemic. They have also been monitoring the health and well-being of the Executive team in an informal way through this challenging period.

28/20 RECEIPT OF MINUTES FROM SUB-COMMITTEES

Minutes of the following meetings were received:
- Quality Committee meetings held on 5.2.20 and 2.3.20
- Workforce Committee meeting held on 18.2.20
- Joint Quality and Workforce Committee meetings held on 4.5.20 and 1.6.20
- Charitable Funds Committee meetings held on 26.2.20 and 24.6.20
- Audit & Risk Committee meetings held on 29.1.20, 7.4.20 and 16.6.2020
- Finance & Performance Committee Meetings held 3.2.20, 2.3.20, 30.3.20, 4.5.20, 1.6.20. The Director of Finance pointed out that the Finance and Performance Committee also monitors performance as well as finance, and that any re-set and stabilization plans will go through this committee.

No questions were raised.

OUTCOME: The Council of Governors **RECEIVED** the minutes from the above sub-committee meetings.

29/20 INFORMATION TO RECEIVE

a. Council of Governors Calendar 2020

The Council of Governor's calendar of meetings for 2020 was circulated for information. This includes all governor meetings, workshops and Divisional Reference Groups.

The Council of Governors meeting scheduled for 22 October 2020 will be a virtual meeting through Microsoft Teams but the Company Secretary is looking at options to make this meeting public.

OUTCOME: The Council of Governors **RECEIVED** the updated Council of Governors Calendar for 2020.

b. Proposed Meeting Schedule for 2021

The calendar of events for the remainder of 2020 were provided for information. The Company Secretary pointed out that although some of these currently show a physical location, it might be necessary to hold them remotely through Microsoft Teams.

The proposed dates for the Council of Governors meetings for 2021 were provided.

OUTCOME: The Council of Governors **RECEIVED** the updated schedule of events for 2020 and the proposed meeting schedule for 2021.

15/20 ANY OTHER BUSINESS

LS thanked the Workforce and Organisational Development team for all of their work over the last few months and mentioned specifically the wobble rooms, boost boxes and open door policy and noted that the frontline staff were very appreciative. This was also echoed by Councillor Lesley Warner.

The Chair thanked the Council of Governors on behalf of the Board for their continued support.

DATE AND TIME OF NEXT MEETING

The Chair thanked the Council of Governors, Non-Executive Directors and Executive Directors for attending the meeting. The Chair formally closed the meeting at 16.56 and invited members to the next meeting.

Council of Governors Meeting
Date: Thursday 22 October 2020
Time: 3:30 – 5:30 pm (private meeting 2:00 – 3:15 pm)
Venue: Microsoft Teams

9. CHS Managing Director Update August 2020

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

(Unconfirmed)

AUGUST 2020

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

1.0 Company Update

Verbal Update

2.0 Service updates

2.1. Estates

2.1.1 Capital Development / Backlog

CHS are currently working through £1,038K to address back-log maintenance for HRI. The team are now working with the Trust procured principle designer (IBM) on all major projects across HRI. Additional to this, the procurement process to select a new PSCP (principle contractor) is on-going with an intention to appoint a new contractor for 5 years in September.

The vacant position as Head of Capital and Property has been awarded to internal candidate Tom Donaghey, Tom will now develop the internal team to deliver the 5-year reconfiguration capital plan.

2.1.2 Community

Work continues to rationalise the estate footprint, CHS on behalf of the Trust have now disposed of Glen Acre House and Acre House Avenue. Acre House – an offer has recently been received and awaiting confirmation. The new Elland property is now complete and we have recently been awarding funding to install a goods lift.

2.1.3 LED Scheme

The LED scheme continues to progress at HRI albeit with challenges around timescales and delivery. The HRI programme has commenced however now with CV-19 delays of around 4 months.

2.1.4 Fire Safety

Fire safety remains an area of focus particularly at HRI, CHFT has commissioned a Trust wide survey with agreement from CHS on an holistic review brief of fire safety across the Trust with focus on fire strategy at HRI. External consultants Mott MacDonalds have been commissioned to carry out this review. Initial document/data sharing has commenced with planned visits and should be complete in September.

The Capital scheme to verify / remediate 60 min compartmentation was impacted by the social distancing measures, there are 16 doors out of 70 to install, difficult due to access.
A subsequent maintenance programme using (FDIS) qualified inspectors will annually verify the 60 min doors with visual inspections conducted on the remaining doors.
Fire Risk Mitigation comes in the form of staff training, weekly / annual Fire Alarm testing, Fire Risk Assessments and subsequent actions monitored by the Trust Fire Safety Committee.

2.1.5 Portland Stone

The Portland stone cladding panels and windows remain a short and long-term risk at HRI, on-going maintenance and remediation continues to address the immediate risk, CHS estates are undertaking a process of due diligence to resolve the longer-term solution / replacement. This option includes over cladding the existing façade. Precedence has been set at Bristol Royal Infirmary while Aintree Hospital is currently completing the design stage and about to begin construction. Several “Go See” visits are being organised for members of the Trust to attend.

To mitigate the risk of falling stone panels a 12 month survey is conducted by structural engineers BWB to assess the condition and movement. Of the original 1515 Portland stone cladding panels inspected and scoring a condition C or above on the scoring matrix it was recorded that a further 24 panels now require imminent attention due to concerns regarding indications of potential movement and their general poor state of condition.

Immediate remediation was carried out using resin anchors effectively bolting the stones to the building. BWB structural engineers now suggest a 6-month inspection to mitigate the risk. This will now need planning into the Capital Plan.

2.1.6 Oxygen
The oxygen infrastructure became critical during the CV-19 peak in particular monitoring of the Vacuum Insulated Evaporator (VIE). Monitoring became twice daily and improvements were made during the peak which ensured the VIE operated as efficiently as possible. Demand peaked to 45% of the overall capacity, now down to less than 17%.

2.1.8 Ventilation
There is now a focus on ventilation air changes rates across health care premises in the management of aerosol generating procedures (AGPs). The resulting work is to ascertain the air change rate per hour (ACH) for every area where patient care may take place across the Trust to assist the Trust in decision making. This work is now complete for HRI.

2.2. Medical Engineering

2.2.1 Asset Tracking
Asset tracking system rollout complete in support of the COVID effort and it is working well.

Scan 4 Safety (S4S) funding business case being compiled for the expansion of the system to other assets throughout the Trust, current plans are for a further 3,500 assets to be tagged in year.

2.2.2 Active Temperature Monitoring
Medical Engineering working with THIS and Pharmacy, in conjunction with the procurement team to ensure a safe route of purchase, which is now completed. The temperature monitoring tags have been delivered and funding secured for the implementation by Medical Engineering Team.

S4S meeting planned to review the escalation process proposed, with Facilities and the Trust. Roll out planned for the middle to late August to enhance CQC compliance for the Trust, the 2 – 3 weeks delay has been due to late order placement and financial sign off.

2.2.3 Support to PPE
Medical Engineering Training team continue to support the PPE group with identification of groups of staff and fit testing information, variation being sought to fund these activities.

2.2.4 Training Development
Medical Engineering Training team continue to develop alternative training resources and methods of training delivery in order to adapt to the ever-changing situation.

2.2.5 New Location for Medical Engineering
Scoping the potential for alternate accommodation for Medical Engineering at HRI in order to facilitate social distancing and working differently under COVID.

2.2.6 Contract Management
Administrative team progressing well with contract renewals and identification of variations and additions to contract at the end of warranty.

2.2.7 Non - Compliant Medical Devices
We are continuing to work closely with procurement to ensure this does not recur.

2.2.8 External Audit/Review of the Medical Devices
The external review of the Medical Devices service by Audit Yorkshire is complete, this has now been sent to CHS Board and a plan is being put in place to address the key points raised within the Audit:

a. Training – CHS training compliance has already been raised to over 75% and is now the most compliant department within the Trust, work continues to improve this position and put a plan in place by October.
b. Governance – Medical Device Management Policy Review is underway due to be complete in month, Medical Device Procurement & Management Group due to restart September, with a clear approval route to purchase for all reusable Medical Devices. Medical Engineering are now a signatory for business case approval at Capital Management Group.
c. Maintenance – A scrub of the data on the asset management database is ongoing as well as enhanced management of maintenance providers, in order to ensure contractual obligations are met.
d. New Medical Devices – with the proposed changes to the Medical Device Management Policy and the strengthening of the Medical Device Procurement & Management Group ties with Capital Management Group & Procurement this will eliminate this problem as much as is possible.

2.2.9 KPI compliance
Due to the influx of a further 950 new Medical Devices and items of equipment, combined with other tasks allocated to the department and already stretched workforce we have failed to attain a Green KPI for Low risk Devices again, a plan is in place and rectification is ongoing, expectation is that the position will change by end of August and compliance will start to increase.

2.2.10 Decontamination and Repair of Mattresses
This still has not moved from the planning phase as we are experiencing problems sourcing training for the Engineering staff from the Original Equipment Manufacturer due to the current Covid situation, planning continues in order to rectify this and realise the potential savings. In cooperation with the Finance team we are still trying to secure the right level of funding for this prior to novating the SLA.

2.2.11 S4S EPR Connectivity
Update this project will need to expand in scope as the Trust are in the process of procuring another 25 devices which will have a significant cost attached, a trial is due to be started with an active system within the next month.

2.2.12 Vacancy/Retirement
After many years with the Trust and Company Brian Bottomley has taken the decision to retire fully, after being the chief medical engineer until he retired, then later returning as a medical device trainer, he has been a stalwart within the department and will be greatly missed, his experience and professionalism were an example to all.

2.2.13 Decontamination Service

Tupe process is ongoing for the positions moving from Surgical Division to CHS Medical Engineering, the SLA is to remain in place for the next 6 months for the decontamination manager position in order to enable a service review and recruitment to take place. In conjunction with Procurement we will be putting together an options paper looking to the future of the service and potential business opportunity.

2.3. Facilities

2.3.1 Brackenbed View Deep Clean

CHS were asked to undertake a deep clean of Brackenbed View care home following a Covid Outbreak. The clean was required at short notice and was extremely hard going as it was a lot dirtier than first thought. The team were brilliant and worked hard and the clean was signed off on Thursday 6th August by Infection Control. Learning has certainly been taken away from the experience but given that it was the first time the department had done anything like this, it was a great achievement.

2.3.2 Transport

First submission of the Transport tender was unsuccessful and received no interest. The tender was sent out again, receiving 1 x response in the week prior to lockdown. The submission proved unsuitable due to the associated costs for the larger vehicles (shuttle buses, tail lift and wheelchair access vehicles), which were substantially higher than anticipated. The bidder was also unable to meet the required response times. Included in the tender is a mixture of hybrids (adhoc cars and shuttle buses) and fully electric vehicles. (smaller vans for the GP routes). The tender process has now been sent out for local providers to apply and closed for submissions on 14 August 2020

2.3.3 ED - “Immediate” KPI

Portering services on both sites spent a 12hr shift with both ED departments to monitor and assist with how transfer requests are entered into Capman. Coordinators were advised as to when they should be applying “routine, urgent and immediate” criteria to the request. Once the information has been run and analysed, the portering manager and Service Performance will feedback on their findings, followed by an action plan.

2.3.4 BICS Training (Cleaning)

A delay to BICS training, again due to CV-19. Update – The BICS are willing to plan for a start date for training following on from receipt of risk assessments from CHS. Domestic services manager is to complete and send.

2.3.5 Catering

The WYAAT piece of work for the main inpatient meals, is now complete which will result in a possible cost pressure of £41K over the next two years. Finance are aware and Procurement have been involved. For CHS to not go with the preferred supplier would incur further costs, in region of £60K.

Currently in talks with NHS supply group to look at a multi temperature drop system for ambient, chilled and frozen goods. If the decision is to proceed with this option, we would see a reduction in our carbon footprint and hopefully see a reduction in costs.

2.3.6 General Offices

The funeral tender has now been completed and awarded to Pearsons Funeral Directors. The contract is due to start on 17 August 2020.

2.4. Procurement

2.4.1 Staffing

Following two (2) months employed as the Interim Head of Procurement, we were pleased to offer Kelly Sanders the substantive head of commercial services and procurement role, with a contract start date of 6th August 2020.

Other vacancies within the team are category manager for professional services, and deputy head of procurement. The funds from the vacant roles will be used to appoint an interim senior category manager whilst a review of the structure is undertaken, and a procurement strategy is written. The interim senior category manager will manage the category and assistant category managers and will oversee the Procurement Programme of Works, the Contract Register, the CIP Workplan and will identify any commercial opportunities available to CHS.

2.4.2 Service Update

Procurement Team continue to support the Trust with the COVID response which has seen other work largely paused. Materials Management have reverted to a five (5) day service, (reduced from seven (7) and six (6) in previous months) to support the distribution of PPE stocks throughout the organisation. Deliveries are no longer required over the weekend due to stock stabilisation. However, the team are required to work additional hours for product recalls which are currently occurring on a weekly basis.

The Buying team have continued to support a mammoth sourcing effort to secure the right stocks at the right time, which has been a difficult job due to current supplier markets.

The team are continuing to support with the Reconfiguration procurement of which the first stage Design Team procurement was concluded earlier this year.

2.4.3 Apprenticeships

Two more individuals are due to start their CIPS L4 apprenticeship in September and they join Dan Freear on the same course which is extremely positive.

3.0 CHS

3.1. Spotlight Award –

Our Spotlight Award winner for July is Joby Benge

Joby was in the main entrance of HRI on the morning of the 13th July when heard shouts of help outside near the hammerhead he immediately rushed to help as he had witnessed 2 nursing staff holding onto the legs of a female patient trying to stop her from throwing herself over the barrier to the road below. Claire Bushby-Muffitt said “Joby assisted them and helped them bring her safely back to the correct side of the barrier so she was no longer in danger from falling”.

3.2. Finance

We continue to work through the financial impact of Covid19 for the forecast in the financial year. To date we have incurred costs on staffing to continue to provide our services. Our forecast is to continue to deliver financial plan.

3.3. Workforce

3.3.1 Attendance

Attendance is being reported differently during the pandemic. Absence data is currently based on headcount rather than FTE and as such cannot be directly compared to normal monthly aggregated sickness stats. These rates are purely to indicate the proportion of headcount absent from an area for a given reason.

Notwithstanding that, non covid related absence rates continue to fall. At 13 August 2020 non covid absence stands at 3.0% (13 staff) and covid related absence at 2.6% (11 staff). These 11 colleagues are all ‘shielding’ staff, the majority of whom will return to work in the

next week, following risk assessments that have already taken place and in line with national and local guidelines. CHS has an overall absence rate of 5.6% compared with 6.3% for CHFT.

3.3.2 Recruitment

Candidates recruited as additional resource for high turnover areas have been contacted to establish their employment position post-covid. We have a contingency should Trac and Trace and isolation prior to hospital admission or a spike in cases impact on staffing levels in the next few months. Discussion is currently taking place to establish whether the contingency we have is sufficient.

3.3.3 BBRAUN/TUPE

Following novation of the BBraun contract to CHS the intention is to recruit to the Decontamination Manager post. The post has been vacant for a period of time, with WYAAT providing support to CHFT in this regard.

The Quality Assurance post which currently sits within CHFT and provides the operational link to BBraun will TUPE transfer to CHS as part of this arrangement. The formal consultation process has commenced with a potential transfer date of 30 September 2020.

3.3.4 OCS Staff (Acre Mill)

Cleaning and Security staff who transferred from OCS to CHS have expressed an interest in transferring to CHS terms and conditions of service. A joint meeting has taken place with staff, HR, Finance and Head of Service following a comparison of both employment packages. It has been agreed to write to the staff setting out individual comparisons. There will be some staff who benefit from moving to CHS terms and some who do not.

3.3.5 Staff Survey action plan

Work has resumed on the above with feedback meetings taking place and actions being developed including a ‘you said we did’ response.

4.0 KPIs

We continue to deliver a large number of KPIs as ‘green’ even with Covid 19 pressures. Only 2 of the 34 Responsive KPIs did not achieve ‘green’ in July. These were Porters Immediate Jobs and Low Risk PPMs in Medical Engineering.

Only 1 of the 9 Efficiency/Finance KPIs did not achieve ‘green’ in July. This was Waste Management. All safe and effective KPIs achieved ‘green’ in July.

5.0 Risks

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

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

- HRI Estates failing to meet minimum condition due to age and condition of the building (20)
- Resus – Collective risk to maintain compliance / upgrade (20)
- ICU – Collective risk to maintain compliance / upgrade (20)
- Medical Engineering - There is a risk of equipment failure from Medical Devices on the current trust asset list (15)

- Fire safety due to breaches in compartmentation, and a lack of compartmentation in some areas, and enough staff trained in fire safety awareness and as fire wardens (in CHFT) (15)
- The façade of HRI (15)
- Incorrect chemical balance in feed water supply to steam boilers (15).

6.0 Recommendation

Shareholders are asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – August 2020

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	3	0
Red Risks High	4	0
Amber Risks Moderate	27	0
Green Risks Low	13	-3
Total	47	-3

Risk ref + score	Strategic Objective	Risk	Executive Lead	Mar 20	April 20	May 20	June 20	July 20	Aug 20
CHS Risk 6903 (CHFT 7444 (12)	Keeping the base safe	Resus – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7271 (CHFT 7442 (12)	Keeping the base safe	ICU – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 5806	Keeping the base safe	Overall condition of the building –There is a risk to areas due to the age, environment and condition of the HRI building.	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7438 (CHFT 7474 (15)	Keeping the base safe	There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time.	Manager Director (SS) Head of Medical Engineering (RR)	=15	=15	=15	=15	=15	=15
CHS Risk 7318 (CHFT 7414 (15)	Keeping the base safe	There is a risk to life and building due to the failed / heavily corroded metal ties that hold back the Portland Stone cladding at HRI, particularly Ward Black 1 South Elevation potentially resulting in falling Stone debris.	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15
CHS Risk 5511 (CHFT ~~7413~~ (15)	Keeping the base safe	Collective Fire Risk – ~~There~~ is a risk of increased fire spread and delayed evacuation at HRI	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15
CHS Risk 7481	Keeping the base safe	Incorrect chemical balance in feed water supply to steam boilers	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15

The Risk Register has been noted by CHS Board

10. Freedom to Speak Up Annual Report

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	3 September 2020
Meeting:	Board of Directors
Title of report:	Freedom to Speak Up Annual Report
Author:	Nikki Hosty, Freedom to Speak Up (FTSU) Guardian
Sponsor:	Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Previous Forums:	Workforce Committee 10 August 2020

Actions Requested (please delete as required):

- To note

Purpose of the Report

The paper provides information regarding Freedom to Speak Up' (FTSU) activity in the Trust since the last annual Freedom to Speak up Annual Board report in June 2019.

Key Points to Note

It is a statutory requirement that the Board of Directors is required to receive and review FTSU activity on an annual basis. Due to an increased workload in response to Covid-19, it was not possible to complete this to meet the deadline of the July 2020 Board meeting. The annual reconciliation has been submitted to the National Guardian's Office by the FTSU Guardian.

EQIA – Equality Impact Assessment

Speaking up about any concern at work is vital because it will help us to keep improving our services for everyone. This is an inclusive channel for raising concerns - available 24/7 365 via the portal.
We have a diverse range of FTSU ambassadors who do not discriminate or judge and are there to listen and commence proceedings to investigate the concern fairly and appropriately.

Recommendation

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

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS

3 SEPTEMBER 2020

FREEDOM TO SPEAK UP ANNUAL REPORT

1. PURPOSE

This paper provides information regarding Freedom to Speak Up' (FTSU) activity in the Trust since the last annual Freedom to Speak up Annual Board report in June 2019.

It is a statutory requirement that the Board is required to receive and review FTSU activity on an annual basis. This paper covers the period 22 June 2019 – 29 June 2020.

The report is presented in a format that ensures compliance with the 'Guidance for Boards on FTSU in NHS trusts and NHS foundation trusts' published by the National FTSU Guardians Office (NGO) and NHS Improvement (NHSI) in May 2018.

2. INTRODUCTION

The intent of the FTSU model is that in time it will be acknowledged, respected and embraced by all at CHFT. The aim of this report is to provide assurance to the Board that the FTSU channels in the Trust are robust, fair, healthy, responsive and that any learning points are acted on, shared and focused on continual improvement.

In 2018 the NGO and NHSI published guidance for Boards. To ensure we comply with 'best practice' the guidance is adhered to. This report has been structured to provide information concerning the following:

Section 1 - The assessment of issues
Section 2 - Potential patient safety or workers experience issues
Section 3 - Action taken to improve FTSU culture
Section 4 - Learning and improvement
Section 5 – Recommendations

3. CONCERNS REPORTED IN 2018/2019/2020

Section 1 - The Assessment of Issues

The table below shows the number and types of cases being dealt with by the FTSU Guardian and the FTSU ambassador volunteers since 2018:

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
Apr – June 2018	2	0	2	1
July – Sept 2018	3	0	1	2
Oct – Dec 2018	4	3	1	2
2018 Total	9	3	4	5

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
Jan – Mar 2019	9	7	2	0
Apr – Jun 2019	18	5	4	4
July – Sept 2019	22	6	6	1
Oct – Dec 2019	18	10	6	1
2019 Total	67	28	18	6

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
Jan – Mar 2020	26	14	12	3
Apr – Jun 2020	26	10	4	5
2020 to date	52	24	16	8

During the reporting period for this annual report (22 June 2019 to 29 June 2020) the figures show:

Date Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
22 June 2019 – 29 June 2020	93	40	29	15

Concerns received are very diverse in nature mostly linked to colleague care, quality and safety rather than patient care, quality and safety.

The main theme over the course of the last 12 months is attitudes and behaviours followed by management decision making/policies & procedures.

Covid Related concerns

Specific attention has been paid to concerns raised during the Covid19 pandemic. Information on concerns raised during the pandemic is set out below:

Period	No. of Concerns	No. raised anonymously	No. linked to element of patient safety / quality	No. linked to bullying/harassment
20 March 2019 – 29 June 2020	28	13	7	5

Covid Themes

The primary themes identified by colleagues as concerns during the pandemic are:

- Lack of social distancing in the workplace
- Unsafe infection control
- Lack of PPE

- Redeployment
- Lack of one culture of care / lack of respect
- Being asked to come into work when other colleagues working from home
- Poor management / leadership

Since the last report there has been:

- A significant increase in colleagues speaking up
- Increase in the number of colleagues volunteering to be an Ambassador
- Increased diversity in the type of colleagues raising their concerns ie porters, clerical assistants, practice managers, theatre orderlies, nurses, Drs and apprentices.
- Increased number of channels to 'speak up' ie debrief / listening events / colleague wellbeing calls and individual wellbeing risk assessment
- Increased emphasis and promotion of 'one culture of care' (where we care for each other the same way we care for our patients)
- Increase focus on colleague accountability, your voice matters and general promotion of how beneficial 'speaking up' is to making a difference in the Trust

The results above are likely as a result of the communications campaign, ambassadors increasing their profile, colleagues gaining trust in the process and expanding the 'speak up' channels and culture that enables trust and confidence that there will be no detriment to colleagues should they speak up and the commitment that one culture of care will be wrapped around colleagues who raise concerns.

Section 2 – Potential patient safety or workers experience issues

Each concern raised has been treated with respect and care, with regular confidential communication with the colleague who has raised their concern and confidential discussions with the leaders responsible for the particular department where the concern has been highlighted. Some investigations have found that there are necessary actions that need to be undertaken to improve patient, care, quality or safety. The Guardian will ensure these concerns are followed up to ensure those lessons learned are implemented and embedded.

The Guardian will triangulate learning and data through relevant management meetings, to identify opportunities to learn and improve.

Section 3 - Action taken to improve FTSU culture

FTSU is discussed at each corporate induction, FTSU ambassadors as well as the Guardian represent FTSU at a variety of meetings / events.

FTSU Ambassadors have taken on more responsibility this year to promote and engage colleagues in respect of the importance of speaking up, what care you can receive from the FTSU team, what the process looks like and what feedback you will receive. This level of transparency has really helped the 'speak up' culture to grow.

The Guardian hosts regular sessions with the FTSU ambassadors where we support one another and wrap 'one culture of care' around each other. Concerns that are coming through are becoming more complex and these sessions allow the ambassadors to ask for support, it's a safe environment and enables strong relationships to be built.

The growth of the 'speak up' culture in the Trust is supported by a range of channels:

- Ask Owen – 'you can ask the Chief Executive anything' - 105 questions have been raised and responded to over the past 12 months (an increase from 100 the previous year). Questions come from all divisions and most staff groups, from HCAs to consultants. They are wide-ranging and cover various topics affecting both staff and patients.

- Staff Survey - 2547 colleagues completed the last survey (46% of the Trust's workforce).

There were two questions relating to FTSU:

Q95: The Trust has a Freedom To Speak Up Guardian and a network of FSUG ambassadors. Are you aware of this?

Yes	1560 responses	66.5%

Q96: The Trust has a FSUG portal for colleagues to raise their concerns. Are you aware of this?

Yes	1187 responses	50.8%

- Individual Health and Wellbeing Risk Assessment
  90.8% (1120) of respondents have said they know about FTSU and where to raise concerns.

- Datix – incident reporting over the 12 month reporting period

Pressure Ulcers/Moisture Associated Skin Damage (MASD)	2946
Slips, trips and falls	1999
Appointment/Admission/Transfer/Discharge	1862
Assessment/Treatment/Diagnosis	970
Medication	969
Maternity Incidents	779
Health and Safety/Sharps/Security	622
Infrastructure/Resources/Staffing	589
Confidentiality/Communication/Consent/IG	526
Abuse/Self-Harm	453
Total Datix incidents recorded (1.6.19 – 31.5.20)	**11715**

<u>Covid Related 'Speak Up' Initiatives</u>

At the start of Covid the Trust recognised it needed to enhance wellbeing support for our colleagues as we work through Covid.

We quickly launched a Colleague Support Package and increased awareness of One Culture of Care.

- We launched a 24/7 / 365 telephone wellbeing support service and through this channel it has enabled 120 colleagues over a 14 week period to call and speak about their anxieties / concerns / worries freely in a non judgemental way.

- Individual Wellbeing Risk Assessment
  All CHFT colleagues have been invited to complete an Individual Wellbeing Risk Assessment. 90.8% (1120) of respondents have said they know about FTSU and where to raise concerns.

- We implemented group listening events / de brief sessions (Bands 1 – 4) to discuss colleagues Covid related experiences, thoughts and feelings and 120 colleagues have been supported through this channel

- Management debrief sessions have also commenced in June 2020 and we hope to speak to 50 colleagues at the end of July.

Through the development of these channels we are creating a safe space/environment for open discussion without blame or judgement and colleagues welcome this and are gaining trust and confidence in 'speaking up'.

The strategy is that these speaking up channels complement one another and work together in partnership with FTSU to drive continuous improvement and positive change.

Section 4 - Learning and Improvement

The Guardian and the team of ambassadors have hosted a number of stalls outside the CRH/HRI canteens and promoted FTSU. Through discussions held at the stalls the team are getting a feel for awareness of the 'Freedom to Speak up' portal, ambassador team and what they think of the FTSU process in respect of support for colleagues raising concerns, taking action, confidentiality and feedback. Information from these discussions are discussed at the FTSU meetings and learnings are implemented into our approach.

Through the implementation of the 24/7 / 365 wellbeing telephone service we are learning a great deal about colleagues' experiences in the Trust. Themes coming through:

- Poor management,
- Poor communication
- Colleagues being treated like a commodity rather than a person
- Anxieties linked to safety and wellbeing of themselves and their family

All the FTSU concerns reported during Covid have been captured and this information has been communicated to the Incident Management Team.

This feedback should support improvements in 'resetting services' and any preparations should we have a second wave.

The NGO has been hosting pulse surveys during Covid, feedback from the most recent survey is highlighted in Appendix one. The NGO has also hosted webinars and regularly provides updates and shares case studies. The CHFT FTSU Guardian finds the information shared from the NGO really useful and shares updates with the CHFT FTSU ambassador community.

The Regional FTSU network is also a great source of learning and support. CHFT FTSU Guardian finds this network invaluable for their learning and development and learnings from other Guardians from other Trusts are threaded into enhancing a 'speak up' culture in our Trust.

Section 5 – Recommendations

Within the next 12 months recommendations are:-

- Develop an FTSU report CHFT colleagues which will share case studies, what improvements have been implemented as a result of the FTSU channels being utilised and how the listen and learn culture is making a difference in the Trust.
- Ensure that learning from FTSU is incorporated into developing patient safety processes.
- Continue to increase the visibility of the 'speaking up' channels
- Analysis of NGO case studies and recommendations identified are discussed within the FTSU team and recommendations for action will be taken as a result of these discussions

4. CONCLUSION

The Board is asked to note the content of this report.

Nikki Hosty, FTSU Guardian
4 August 2020

Appendix 1

COVID-19 Pulse Survey: Results of third survey published

The results of our latest pulse survey have been published on our website. This was the third edition in a series of pulse surveys to measure the impact that COVID-19 is having on Freedom to Speak Up.

Workers continued to be encouraged to speak up with 93% of respondents indicating this – up from 72% in April.

When asked about the types of issues workers were speaking up, the biggest percentage of respondents (79%) selected worker safety and wellbeing. There was a large increase in the percentage of respondents reporting that workers were speaking up about the impact of COVID-19 on black, Asian and minority ethnic workers and also a sharp increase in workers reporting behavioural issues.

As your organisations begins to focus on the COVID-19 recovery phase, Freedom to Speak Up Guardians provide valuable insight into workers' experience. This crisis is an opportunity to listen to workers' voices for learning and improvement, yet most respondents (56%) reported that Freedom to Speak Up guardians were not involved in recovery plans.

11. 11. Update from the WYH Partnerships Chief Executive Lead 26-20

West Yorkshire and Harrogate Health and Care Partnership

WY&H Health and Care Partnership Board

1 September 2020

Summary report	
Item No:	26/20
Item:	**Update from the WY&H Partnership's Chief Executive Lead**
Report author:	Rob Webster, Chief Executive Lead, WY&H Health and Care Partnership
Presenter:	Rob Webster, Chief Executive Lead, WY&H Health and Care Partnership

Executive summary

The COVID-19 pandemic continues to provide the focus for our work across the Partnership. The purpose of this paper is to update the WY&H Partnership Board on the focus and priorities of our Partnership work over the past three months as well as plans for the remainder of this financial year in the context of both COVID-19 and our Five Year Plan.

Recommendations and next steps

Members of the WY&H Partnership Board are asked to note the report.

Update from the West Yorkshire and Harrogate Health and Care Partnership's Chief Executive Lead

Purpose

1. The COVID-19 pandemic continues to provide the focus for our work across the West Yorkshire and Harrogate (WY&H) Health and Care Partnership. The purpose of this paper is to update the WY&H Partnership Board on the priorities of our Partnership work over the past three months, as well as plans for the remainder of this financial year in the context of both COVID-19 and our Five Year Plan.

A reminder of our context

2. There are well established arrangements at system level, through the West Yorkshire Resilience Forum, and locally with councils, the NHS, community and voluntary organisations and other partners working together in each of our six places (Bradford district and Craven; Calderdale, Harrogate, Leeds, Kirklees and Wakefield) to co-ordinate our response on COVID-19.

3. Within the NHS there is a formal command-and-control structure, with incident management centres at national, regional and organisational levels. All national requirements are communicated through single points of contact (SPOC) at these levels.

4. The WY&H Partnership does not duplicate these arrangements or create additional oversight or reporting mechanisms. We are, however, clear that the relationships and ways of working we have established through the Partnership over the past four years add value in supporting the response. We also have the staff with the capacity and skills to work in different ways as required. This has proven to be the case.

5. We work to identify specific tasks where WY&H Partnership working can add value, in line with our three tests of a) working at scale to achieve critical mass; b) sharing good practice; and c) tackling issues together. It is clear that this is a uniquely fast moving environment and priorities and pressure points will change frequently and that an agile response is essential.

6. While the specific focus of our work has changed, our Five Year Plan that we agreed in December 2019 continues to set the high level priorities that we are working towards. Some of the work we have been doing related to these and the 'ten big priorities' we set ourselves is covered here.

7. The economic impact of COVID-19 has led to a recession which brings additional risks to the health of our population. It also means that the potential economic benefits of the health and care system in terms of jobs, large capital schemes, innovation and med tech must be secured. The West Yorkshire Economic Recovery Board (ERB) is chaired by Councillor Suzanne Hinchcliffe, Leader of Bradford Council. The Partnership feeds directly into the ERB and the role of our sectors in supporting the economy and health is reflected in the draft plan.

8. Since our last meeting, a Harrogate System Alignment Memorandum of Understanding (MoU) has been developed and agreed setting out the details of an agreement on the involvement of Harrogate and District NHS Foundation Trust and NHS North Yorkshire Clinical Commissioning Group in networks, systems and processes in the Humber Coast and Vale Health and Care Partnership and WY&H Health and Care Partnership.

Current position

9. The COVID-19 pandemic has moved from a level 4 national incident to a level 3 incident, managed at regional and local level. This reflects reductions in incidence of infections over time and fewer deaths. The Government's strategy has moved to one of easing national restrictions and managing the position through local measures. This has been represented by a national surveillance approach which places areas in categories of increasing concern and potential intervention.

10. From Tuesday 18 August, Public Health England (PHE) and NHS Test and Trace, as well as the analytical capability of the Joint Biosecurity Centre (JBC) came under a single leadership team called The National Institute for Health Protection (NIHP). The organisation will be formalised and operating from spring 2021 and will support local directors of public health and local authorities on the frontline of the COVID-19 response. Our public health teams and colleagues continue to work closely with us on all other aspects of work undertaken by PHE, including screening, vaccination, intelligence and health improvement.

11. Since we met on 2 June 2020, we have seen areas of WY&H featuring in the Government's surveillance list frequently. This has led to restrictions to the easing of lockdown being imposed in Bradford, Calderdale and Kirklees, as well as Wakefield being an area of interest. There are currently restrictions on household visitors in the Bradford, Calderdale and Kirklees areas.

12. The number of people testing positive for coronavirus in Yorkshire and Humber is amongst the highest in England, with the number in West Yorkshire higher again. Latest available data (week 33 covering the period 10 -16 August) shows that in England the 7 day rate was 12.2 per 100,000. In Yorkshire and Humber the rate was 18.7 per 100,000; this is higher than all other regions, with the exception of the North West.

Table 1: Weekly rates of COVID per 100,000 population:

	7 day rate per 100,000 population					
	Week 28	**Week 29**	**Week 30**	**Week 31**	**Week 32**	**Week 33**
Bradford District	38.35	43.19	48.59	52.87	54.92	53.43
Calderdale	23.32	23.32	30.46	39.98	45.22	35.7
Kirklees	28.26	28.04	21.2	26.21	31.45	34.87
Leeds	8.36	6.84	5.2	16.35	14.06	16.22
Wakefield	19.13	18.26	14.2	14.78	17.97	20.58
Y&H PHE Centre	13.2	14.1	12.9	15.7	17.1	18.7

Source: National COVID-19 Surveillance Report

13. The number of daily infections across West Yorkshire has risen throughout July and the first few weeks of August as parts of the economy have begun to open up, and lockdown restrictions eased. As of the 21 August, this growth in cases is showing signs of slowing, with the 7 day rate beginning to stabilise across all local authority areas.

14. Throughout July and August we have seen outbreaks in a range of settings including care homes and workplaces, and a small number in secondary care settings. Some of the most notable outbreaks have been in the food processing industry and in bed factories; staff working in some of these settings not only work together, but travel to work, live and socialise together, highlighting the need to promote social distancing both inside and outside of the workplace. Most of the cases identified in care home settings have been single cases in staff, sometimes residents; we are not observing the same levels of transmission in care homes that we saw earlier in the year.

15. The increase in incidence of coronavirus throughout July and early August has not impacted on hospital activity. COVID-19 related hospital activity has continued to fall month on month from the peak in April and remains low. Similarly, mortality has also reduced and there are now fewer deaths in West Yorkshire than we normally see at this time of year.

16. The low levels of hospital activity and low mortality rate are primarily a result of the low number of cases in older age groups, with cases highest in the 20-49 year age group. Household transmission has been a feature in West Yorkshire; similar to other parts of the North of England, but more recently there has been transmission in the community, notably in younger adults.

17. Despite this, national changes have occurred to people who are shielding, with the advice on those facing lockdown being eased. As a system we have continued to support people who are shielding / households as appropriate.

Phases of the COVID-19 response

18. Nationally, NHS England / NHS Improvement have set out four phases for planning the NHS response to the pandemic. These are as follows:

Phase	Time period	Response
1	Jan-April 2020	Focus on critical care and building capacity to respond to COVID-19
2	April-June 2020	Immediate recovery actions post-COVID-19 surge Focus on urgent activities
3	July 2020 – March 2021	More comprehensive planning review Focus on building elective and potential COVID-19 spike during the winter phase
4	April 2021 onwards	Focus on recovering and developing the NHS towards the 'new normal'

Partnership priorities in phase three: July 2020 to March 2021

19. The Government move from a 'National Level 4 Incident' to a 'Level 3 incident' is set out in detail here. This reflects a move towards regional mechanisms to co-ordinate the response, and reflects the fact that we are now in a period where there are greater localised outbreaks of the virus.

20. This phase of working is not one of full recovery. The focus is on how we can provide care and services while continuing to deal with the presence of COVID-19 in our population. These dual aims increase the complexity of planning and delivery, and require significant agility in places and system, service and staff resilience.

21. Our partnership priorities during this phase are as follows:

- Continuing to provide **critical and urgent care for COVID-19 patients**, their recovery and rehabilitation
- Providing **essential health and care services during the COVID-19 incident for other groups** of people
- Continuing to support **people who are shielding** from the virus, as well as supporting other groups who are likely to be affected by it
- Keeping **health and care colleagues** safe and well
- Understanding the **wider impact on different groups** of people, including Black Asian and minority ethnic communities (BAME), older people, people with learning disabilities and/or mental health concerns and other vulnerable people
- **Co-ordinating our reset** to the new 'normal' (stabilisation and reset), including responding to future peaks.

22. There is significant work happening in relation to each of these priorities, and all West Yorkshire and Harrogate priority programmes have been refreshed in line with them. Some of the key priorities are set out below:

Services for people with COVID-19

23. We continue to provide **critical and urgent care** for COVID-19 patients, their recovery and rehabilitation. The number of people requiring critical and urgent care has declined significantly since the peak in April 2020.

24. Effective management of critical care capacity is essential during this period, as we will need to manage demand relating to both COVID and non COVID patients as services are restored. Mel Pickup, CEO of Bradford Teaching Hospitals, has agreed to be the senior sponsor for our Critical Care Network to ensure alignment with our wider plans for restoration of services.

25. The NHS Nightingale Hospital Yorkshire and the Humber has provided important extra capacity for patients and staff as the NHS cared for people with COVID-19 whilst also maintaining other frontline services. An extension to the contract has now been agreed, which will mean more essential health checks, including for cancer, can continue to be delivered in Harrogate - with over 1,200 patients having already had a scan at the facility - while also offering back-up capacity as the country continues to deal with the virus.

Personal protective equipment (PPE) and testing

26. One of the major challenges we faced in the early stages of the pandemic was the global shortage of PPE. Over Easter we relied on the generosity of local partners and businesses to prevent health and care providers from running out of vital items such as gowns and masks.

27. To reduce the risk of this happening again we set up a joint programme to establish and maintain a resilient supply of PPE for partners in the WY&H Partnership, working closely with the Local Resilience Forum (LRF), with the aim of creating a one month stockpile of PPE. A programme board has been led by Mel Pickup to oversee this work, supported by procurement leads from across the partnership and a clinical reference group to assess the suitability of non-standard items. Through the programme we have been working to develop new sources of supply, including local manufacturing, and ensuring that the stock we have has been used as efficiently as possible. We have now agreed to continue this programme through until March 2021 to support both health and social care partners.

28. Also around April 2020, at the height of the pandemic, we had to work together to build up our capacity for COVID testing in West Yorkshire. Martin Barkley, CEO for Mid-Yorkshire Hospitals NHS Trust, has led a programme on behalf of the ICS and LRF to do this. As well as building up the capacity of our NHS labs we worked with the national programme to open regional testing centres in Leeds and Bradford, and also satellite sites in Wakefield, Halifax, Huddersfield and Keighley, as well as additional walk-in sites and mobile units, initially operated by the army. We have now tested around 140,000 people through these 'pillar 2' sites (accurate at 12 August 2020).

29. More recently the programme has been broadened to support our Directors of Public Health and their teams to develop local outbreak management plans, and to share learning and experiences on the management of the outbreaks we have seen in a number of areas of West Yorkshire.

30. The programme is now also rolling out the opportunity for health and care staff to be tested for COVID-19 antibodies, to indicate whether they have previously been infected by the virus.

31. Care home testing whilst in place has not yet reached the planned frequency of weekly test as had been anticipated.

Providing other essential health and care services during the COVID-19 incident

32. A core focus for the majority of our programmes is how we provide essential services in the context of COVID-19. For services such as planned care and cancer the focus is on how we can provide services to those with the greatest need while maintaining separation of COVID and non-COVID facilities. The acute hospitals are working closely together. For mental health services, we are beginning to see an increased demand for services at both ends of the spectrum, whether those with low level anxiety or those with significant mental ill health as the longer term impact of the pandemic and lockdown takes effect and the real risks associated to the worst economic recession experienced for many years. The focus of the Urgent and Emergency Care Programme is embedding the 'talk before you walk' model of access, and ensuring a co-ordinated

approach to messaging on access to services, with the potential of a national roll out in December 2020.

33. The WY&H Clinical Forum members have developed 'An Ethical Framework' for the area that can be applied to adults across West Yorkshire and Harrogate health and care system. This has been generated by looking across a wide range of sources of ethical thinking that has been published in recent months. The aim is not to replicate or replace any of this good work, it is to draw on it and make relevant for colleagues across the area.

34. The take up of the winter flu vaccination has even greater importance this year, given the risk of a flu spike coinciding with spikes in COVID-19. The phase 3 planning guidance sets out requirements for significant expansion of the vaccine programme so that all staff and 75% of people in at risk categories are vaccinated.

35. Our response on this will be led locally, and to support these local arrangements Owen Williams, CEO for Calderdale and Huddersfield NHS Foundation Trust and Carol McKenna, Chief Officer for Greater Huddersfield Clinical Commissioning Group and North Kirklees Clinical Commissioning Group, have agreed to chair a WY&H Forum to share good practice, address common barriers to progress and ensure that the approach is fully aligned with our local places (Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield) and priorities on health inequalities.

Support for people who are shielding

36. The overall Government advice to shield at home was paused on 1st August 2020, as prevalence of COVID-19 remains at a low level across England.

37. In West Yorkshire (not including those living in Craven and Harrogate) there are 111,165 people in the shielding group who remain classed as Clinically Extremely Vulnerable and are being advised to resume normal activities wherever possible and it is safe to do so and to take extra precautions to prevent coming into contact with the virus.

38. There are a smaller number of people who remain advised to shield at home because they are in active treatment or are awaiting surgery.

39. The Government provided food boxes were stopped at the end of July 2020 when the pause began, but all local authority areas in West Yorkshire continue to provide direct support to people in the shielding group, through welfare, emotional and social support.

40. The working assumption is that there may well need to be a future iteration of the shielding at home advice, at local or national levels. There are a number of scenarios where the shielding advice might change or be fully re-instated. This includes a combination of factors:

    - clinical guidance that shielding should restart specifically for the clinically extremely vulnerable population;

- a local or national lockdown is introduced that affects shielding residents: clinical guidance is issued that shielding should restart in a defined local area / or nationally; and
- a significant increase in transmission rates that pose a threat to the clinically extremely vulnerable population – locally or nationally – so additional guidance about staying safe is issued.

41. All local places are currently using the pause period to plan for a future scenario when the advice to shield at home may need to be reissued. This includes working across place local health and care systems as well as with other local resilience partners to ensure that lessons are learned from the first period of shielding and that any future iteration of the support offer is done in collaboration with people from the shielding group.

Supporting health and care staff

42. People working in the health and care sector continue to respond magnificently to the pandemic. Supporting them to stay safe and well during our response is our priority.

43. We have adopted several different responses at both place and system level which adds resilience for staff. Local examples include but are not limited to Bradford District Care Trust identifying additional psychological and counselling capacity to supplement local E-support for 12 months and helpline support for all health and care staff across the Calderdale Kirklees Wakefield footprint. We are also progressing work on a resilience hub, to support the ongoing resilience of staff during the pandemic.

44. We have also commissioned, at scale, the WY&H Grief and Loss Support Service for anyone affected by bereavement during the COVID-19 pandemic.

45. We know that the virus impacts more greatly on Black Asian and minority ethnic (BAME) staff and communities. Since our last meeting we have established a review into the work we are already doing across the partnership chaired by Professor Dame Donna Kinnair. We look forward to receiving recommendations on what else we can do to support this group. Further information on this will be provided at Item 28/20 on the agenda.

46. Carers have been disproportionately impacted by this virus. 70% of carers are providing more care as a result of local services reducing. This is alongside 69% of all carers providing more help with emotional wellbeing and 81% of carers are spending more money (Carers UK, State of Caring 2020). Carers' resources have been produced in partnership with local carer organisations, with some activities receiving national recognition via national roll out, for example the carers working passport. All hospital trusts have signed up to using the carers' discharge packs and we have developed a carers' toolkit, including the 'Plan B' support for all carers.

47. The NHS People Plan was published in early August 2020. Our intention is to develop a revised WY&H People Plan for the end of this year. This will cover all sectors. Our response will reflect the breadth of our Partnership, building on our work with the universities sector and the emerging approach to devolution. Initial work will be covered in the high level plans required by the end of September 2020.

Understanding the wider impact on population groups

48. We know that the virus and the impact of the lockdown restrictions impact differentially across different groups of people, and that this will further widen health inequalities. We are working as a system, using intelligence and insight to understand the disproportionate impacts of COVID-19 on population health. Including work with Bradford Institute for Health Research to understand the direct impacts on BAME groups and those in the most deprived decile.

49. We are using this insight to work with programmes and places to identify high impact preventative interventions that we can focus towards groups disproportionately impacted by the indirect impact of COVID-19. E.g. vaccinations and immunisations, health promoting hospital trusts, diabetes prevention.

50. We have also distributed over £0.5m of funding to thirteen local voluntary and community sector organisations with a specific focus on supporting groups most impacted by the virus. Seven of which directly focus on BAME health inequalities.

51. The WY&H Health Inequalities Network within the WY&H Improving Population Health Programme brings together system approaches to understand and address health inequalities. Progress includes prioritising areas of transformation, for example £100,000 to improve access to specialist mental health services for rough sleepers, £100,000 to improve support for young carers, £50,000 for reducing violent crime towards women and girls.

52. The NHS England / NHS Improvement phase 3 letter provides a number of requirements for system action to reduce health inequalities. A central part of responding to COVID-19 and restoring services must be to increase the scale and pace of the action to tackle health inequalities to protect those at greatest risk. NHS England and NHS Improvement commissioned a national advisory group of leaders (July 2020), chaired by Dr Owen Williams, CEO for Calderdale and Huddersfield NHS Foundation Trust. This group identified eight urgent actions which will give us the opportunity to accelerate existing work across the Partnership to better understand and address health inequalities. The asks centre around eight themes; protecting those vulnerable to COVID-19, inclusive reset, digital inclusion, targeted prevention, mental health, strengthened leadership, improved understanding of inequalities and local collaboration and planning. The Improving Population Health Programme will aim to support and facilitate the system delivery of these ambitions through working with place planners and partnership programmes.

Co-ordinating our stabilisation and reset planning

53. Local planning processes have been in place since late May to co-ordinate planning for the remainder of this year. During July we held conversations with each place to understand their priorities, constraints, and what support could be provided. This process demonstrated the strength of leadership and collaboration in each place. At the end of July NHS England issued further guidance on the requirements of the system for phase 3.

54. Further information on our response to this is provided at Item 27/20 on the agenda.

55. Colleagues have been contributing to the work of the West Yorkshire Economic Recovery Board. This Board has been developing the West Yorkshire Economic Recovery Plan. This includes a broad and ambitious package of interventions to support good jobs and resilient businesses to ensure everyone can have the skills they need, whilst developing an infrastructure that unlocks economic opportunities and delivers resilience to our communities. This plan includes a detailed set of asks for investment from the Government for a total of £1.1bn, including a significant asks that are vital for population health, such as investment into employment support and innovation. We continue to work closely with the West Yorkshire Combined Authority to ensure our economy recovers in a way that is most beneficial to people's health and reduces inequalities.

Third Sector Resilience: Before and during COVID-19

56. Our voluntary community partners and charities are playing a crucial role in supporting those who are most in need, building on the strength and relationships they already have with local communities and neighbourhoods. We need to do all we can to support them and to address the future of the sector. Targeted funds, a new series of support via webinars to share learning and good practice and working together have helped so far.

57. The Partnership's Harnessing the Power of Communities Programme published a report in July 2020 titled 'Third Sector Resilience: Before and during COVID-19'. Over 300 VCS organisations employing over 7,000 members of staff and thousands of volunteers, responded to the WY&H survey. Of these organisations 55% do not expect to be financially sustainable beyond the end of 2020, unless something changes. The report highlights the impact of COVID-19 on the sector and make five recommendations for the Partnership to take forward. This will be discussed at Item 29/20 on the agenda.

Communication and Engagement

58. At its meeting on 2 June 2020, the WY&H Partnership Board considered the early findings of Healthwatch organisations across West Yorkshire, Harrogate and Craven on the experiences of people accessing health and care services across the COVID-19 pandemic. Findings from this work along with feedback received from other partners (including Yorkshire Cancer Community, Sikh Elders Service (Leeds), Carers UK and Bradford Talking Media) was collated and published on the WY&H Partnership's website: *Coronavirus engagement report for stabilisation and reset (August 2020).* This report is a live document and will be updated accordingly.

59. Our communications and engagement plan sets out our principles for communications, engagement and consultation and our approach to working with local people. We also have a summary 'plan on a page' version of the communications and engagement plan and you can also view our easy read version here. Engaging and communicating with partners, stakeholders and the public in the planning, design and delivery is essential if we are to get this right.

Financial and capital

60. As a result of a shift in focus towards COVID-19 at the beginning of the financial year, there have been a number of significant implications on the financial architecture and stability of all sectors across the Partnership. In the NHS, many of the usual financial arrangements have been suspended for at least the first four months of 2020/21, and has been replaced with a revised framework which sees clinical commissioning groups (CCG) paying NHS Trusts a block payment based on 2019/20 financial values, with all organisations then receiving additional top-ups to cover increases in the cost base, including costs specifically linked to the COVID-19 response.

61. At present, full details about the NHS financial regime for the second half of the financial year are yet to be announced. The interim arrangements put in place for the first four months of the financial year have been extended for a further two months until the end of September, and more detailed guidance is unlikely to be released until ongoing discussions between the Department of Health and Social Care (DHSC) and government are concluded. Until then we are working closely with all NHS organisations across the Partnership to gain a robust understanding of forecast expenditure between now and the end of the year; aligned to the activity and workforce planning that is currently underway.

62. National discussions about local authority funding from central government and the impact of COVID-19 on fees and expenditure continue, with concerns expressed about the impact of a potential second wave of COVID-19 cases on the ability of local authorities to respond within existing resources.

63. Over recent weeks we have been working closely with clinical, operational and finance colleagues to ensure we are able to maximise our access to capital funding sources as they are announced. In May 2020 we were notified that NHS provider organisations had a total non-COVID capital envelope of £111m and this has been allocated across the NHS providers in West Yorkshire. Since then a further allocation of £24m has been announced to support critical infrastructure backlog maintenance. We have also submitted further requests for capital funding to support Phases 2 and 3 of the response to COVID-19, and continue to work as a partnership to maximise funding across West Yorkshire.

National Integrated Care System (ICS) policy development

64. In recent weeks NHS England and NHS Improvement have restarted national work on ICS development. The aim of this work is to provide a clearer vision for ICSs, and practical steps to support systems to make progress towards this vision. Their ambition is to have full national ICS coverage by the end of this financial year.

65. WY&H is considered to be one of the most advanced systems in the country. Our model of working – particularly in relation distributed leadership, local authority partnership and mutual accountability continues to influence national thinking. The Partnership's Five Year Plan and 10 big ambitions remain relevant and still feel right in the approach we are taking. They now need to be seen in the context of the pandemic, recession and increased inequalities.

66. We remain committed to the model of working we have developed over the past four years. The principles of subsidiarity, distributed leadership and the concept of the partnership as servant to place still drive what we do. A number of leaders across our system are actively playing into these conversations, and we will continue to advocate for this model of working.

Recommendation

67. Members of the WY&H Partnership Board are recommended to note this report.

Rob Webster
CEO Lead, WY&H Health and Care Partnership