Public Board of Directors 2 July 2020

The following items are for Board Assurance

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 2 July 2020
Meeting:	Board of Directors
Title:	Month 2 Finance Report
Author:	Philippa Russell – Assistant Director of Finance
Sponsoring Director:	Gary Boothby - Director of Finance
Previous Forums:	Finance and Performance Committee

Actions Requested:
For assurance only

Purpose of the Report

To provide a summary of the financial position as reported at the end of Month 2 (May 2020)

Key Points to Note

Year to Date Summary

The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for at least the first four months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £5.80m of retrospective top up funding: £3.39m in M1 and £2.41m in M2.

- Year to date the Trust has incurred £6.82m in relation to Covid-19, of which £2.36m relates to gowns which were purchased by the Trust on behalf of the region. The underlying cost of Covid-19 from a Trust perspective is therefore £4.46m.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £1.03m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- Divisional plans have been retained as per the original business as usual internal plan. The adjustment to the NHSI derived breakeven plan has been held centrally at Trust level. NHS Clinical contract income has been allocated to divisions based on their planned level of activity and income, following the fixed block principle of the national allocations. As such divisional variances represent the financial impact of operational changes as a result of Covid-19 on other income generation and most notably to expenditure.
- Whilst there is no national expectation of CIP delivery, the Trust continues to deliver some savings as planned. CIP achieved year to date is £0.64m, £1.82m lower than planned.
- Agency expenditure year to date is £0.58m, £0.38m below the planned level.

Forecast

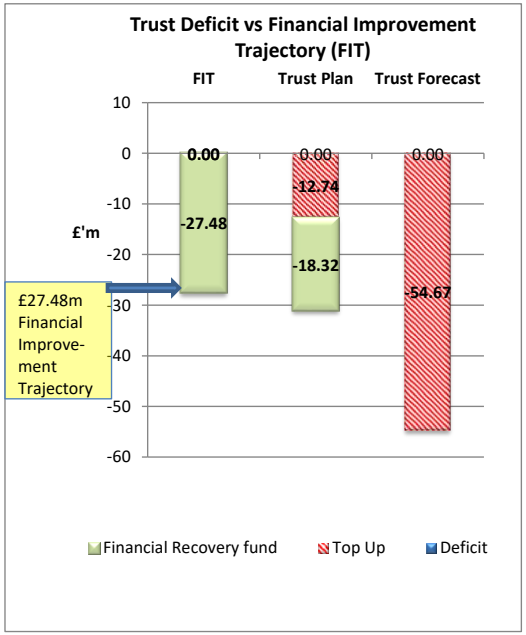
Covid-19 costs and the ongoing impact of the current situation on activity and income have been assessed for M3 and 4 and a retrospective top up of a similar scale to that required in

M2 is forecast for the next couple of months. Pending further guidance on M5-12, the forecast assumes that the Trust will continue to receive CCG clinical income at current block levels, that Covid-19 costs and activity levels will remain at a broadly similar level to those seen in M2 and that the Trust will continue to have access to some sort of top up funding in future months to bridge the financial gap. Work to assess future capacity and the cost of delivering services based on current infection prevention and control guidance is ongoing but is not yet sufficiently progressed to accurately inform the financial forecast at this stage. Appendix: Finance Report Month 2
EQIA – Equality Impact Assessment
The attached paper is for information only. Where this information is used to inform changes to services, policies or procedures, an Equality Impact Assessment will first be completed to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.
Recommendation
The attached summary is for information.

EXECUTIVE SUMMARY: Total Group Financial Overview as at 31st May 2020 - Month 2

KEY METRICS

	M2				YTD (MAY 2020)				Forecast 20/21			
	Plan £m	Actual £m	Var £m		Plan £m	Actual £m	Var £m		Plan £m	Forecast £m	Var £m	
I&E: Surplus / (Deficit)	£0.00	£0.00	£0.00		(£0.00)	(£0.00)	£0.00		£0.46	£0.46	£0.00	
Agency Expenditure	(£0.48)	(£0.21)	£0.27		(£0.96)	(£0.58)	£0.38		(£6.77)	(£3.84)	£2.93	
Capital	£1.60	£1.22	£0.38		£1.92	£1.54	£0.38		£16.21	£15.87	£0.34	
Cash	£6.05	£55.19	£49.14		£6.05	£55.19	£49.14		£3.99	£47.06	£43.07	
Borrowing (Cumulative)	£161.70	£161.70	£0.00		£161.70	£161.70	£0.00		£19.88	£19.88	£0.00	
CIP	£1.23	£0.31	(£0.91)		£2.46	£0.64	(£1.82)		£14.77	£8.52	(£6.25)	
Use of Resource Metric	3	2			3	2			3	2		



Year to Date Summary

The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for at least the first four months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £5.80m of retrospective top up funding: £3.39m in M1 and £2.41m in M2.

- Year to date the Trust has incurred £6.82m in relation to Covid-19, of which £2.36m relates to gowns which were purchased by the Trust on behalf of the region. The underlying cost of Covid-19 from a Trust perspective is therefore £4.46m.
- The underlying position excluding Covid-19 costs is a year to date favourable variance of £1.03m, driven by the impact of lower levels of other activity on non-pay costs and staffing vacancies.
- Divisional plans have been retained as per the original business as usual internal plan. The adjustment to the NHSI derived breakeven plan has been held centrally at Trust level. NHS Clinical contract income has been allocated to divisions based on their planned level of activity and income, following the fixed block principle of the national allocations. As such divisional variances represent the financial impact of operational changes as a result of Covid-19 on other income generation and most notably to expenditure.
- Whilst there is no national expectation of CIP delivery, the Trust continues to deliver some savings as planned. CIP achieved year to date is £0.64m, £1.82m lower than planned.
- Agency expenditure year to date is £0.58m, £0.38m below the planned level.

Key Variances (compared to NHSI derived plan)

- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The assumed 'Retrospective Top Up' of £5.80m drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients. Overall the direct impact of Covid-19 on income generation is a £0.72m adverse variance, including a reduction in Car Parking and Catering income.
- Pay costs are £1.42m above the planned level year to date due to the impact of Covid-19 which are calculated to be £2.24m year to date. The costs attributed to Covid-19 were offset to some extent by underspends in some specialties due to reduced activity and a level of unfilled vacancies in non-Covid impacted areas.
- Non-pay operating expenditure are higher than planned by £2.07m. The costs directly attributable to the Covid-19 response are £4.58m, offset to some extent by lower than planned costs for specialties that have seen lower than planned activity over the last few weeks. This includes lower than planned consumables and a favourable variance on high cost drugs which would usually be treated as pass-through, but related income is temporarily fixed.

Forecast

Covid-19 costs and the ongoing impact of the current situation on activity and income have been assessed for M3 and 4 and a retrospective top up of a similar scale to that required in M2 is forecast for the next couple of months. Pending further guidance on M5-12, the forecast assumes that the Trust will continue to receive CCG clinical income at current block levels, that Covid-19 costs and activity levels will remain at a broadly similar level to those seen in M2 and that the Trust will continue to have access to some sort of top up funding in future months to bridge the financial gap. Work to assess future capacity and the cost of delivering services based on current infection prevention and control guidance is ongoing but is not yet sufficiently progressed to accurately inform the financial forecast at this stage.

Total Group Financial Overview as at 31st May 2020 - Month 2

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

YEAR TO DATE POSITION: M2

CLINICAL ACTIVITY

	M2 Plan	M2 Actual	Var
Elective	896	167	(729)
Non-Elective	9,977	6,817	(3,160)
Daycase	6,783	1,517	(5,266)
Outpatient	58,152	22,606	(35,546)
A&E	26,699	16,336	(10,363)
Other NHS Non-Tariff	282,910	81,356	(201,554)
Other NHS Tariff	21,130	10,775	(10,355)
Total	**406,547**	**139,575**	**(266,972)**

TOTAL GROUP: INCOME AND EXPENDITURE

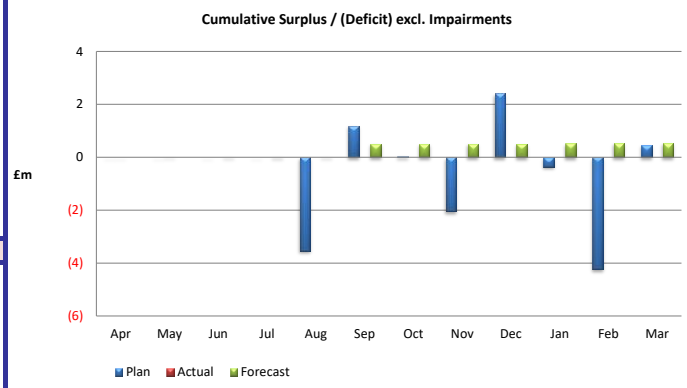
	M2 Plan	M2 Actual	Var
	£m	£m	£m
Elective	£2.93	£2.93	£0.00
Non Elective	£18.63	£18.63	£0.00
Daycase	£4.80	£4.80	£0.00
Outpatients	£7.25	£7.25	£0.00
A & E	£3.91	£3.91	£0.00
Other-NHS Clinical	£19.04	£18.97	(£0.07)
CQUIN	£0.63	£0.63	£0.00
Other Income	£9.26	£7.12	(£2.14)
Total Income	**£66.46**	**£64.25**	**(£2.21)**
Pay	(£44.51)	(£45.93)	(£1.42)
Drug Costs	(£7.08)	(£6.45)	£0.63
Clinical Support	(£4.39)	(£4.47)	(£0.08)
Other Costs	(£10.50)	(£13.11)	(£2.61)
PFI Costs	(£2.21)	(£2.21)	£0.00
Total Expenditure	**(£68.69)**	**(£72.18)**	**(£3.49)**
EBITDA	**(£2.22)**	**(£7.93)**	**(£5.71)**
Non Operating Expenditure	(£4.15)	(£4.24)	(£0.09)
Surplus / (Deficit) Adjusted*	**(£6.37)**	**(£12.17)**	**(£5.80)**
Conditional Funding (MRET/FRF/Top Up)	£6.37	£12.17	£5.80
Surplus / Deficit*	**(£0.00)**	**(£0.00)**	**£0.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

	M2 Plan	M2 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£2.03	£3.60	£1.56
Medical	£6.51	£5.60	(£0.92)
Families & Specialist Services	(£1.59)	(£0.91)	£0.68
Community	(£0.35)	(£0.53)	(£0.18)
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£7.25)	(£7.74)	(£0.49)
THIS	£0.38	£0.15	(£0.24)
PMU	£0.59	£0.56	(£0.04)
CHS LTD	£0.07	£0.06	(£0.01)
Central Inc/Technical Accounts	(£1.28)	(£0.55)	£0.72
Reserves	(£0.47)	(£0.22)	£0.24
Unallocated CIP	£1.34	£0.00	(£1.34)
Surplus / (Deficit)	**(£0.00)**	**(£0.00)**	**£0.00**

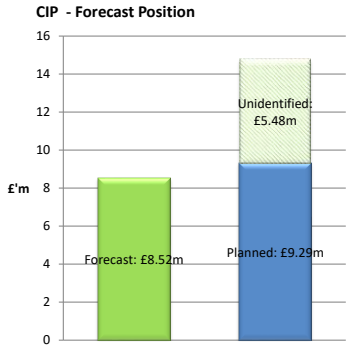
TOTAL GROUP SURPLUS / (DEFICIT)

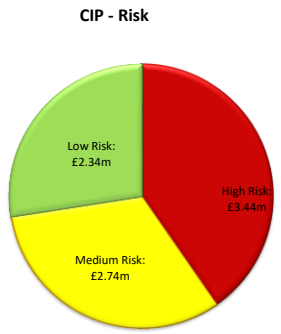


KEY METRICS

	Year To Date M2 Plan	Year To Date M2 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£0.00)	(£0.00)	£0.00	£0.46	£0.46	£0.00
Capital	£1.92	£1.54	£0.38	£16.21	£15.87	£0.34
Cash	£6.05	£55.19	£49.14	£3.99	£47.06	£43.07
Loans	£161.70	£161.70	£0.00	£19.88	£19.88	£0.00
CIP	£2.46	£0.64	(£1.82)	£14.77	£8.52	(£6.25)
	Plan	Actual		Plan	Forecast	
Use of Resource Metric	3	2		3	2	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£14.77m** **Total Forecast** **£8.52m**

YEAR END 20/21

CLINICAL ACTIVITY

	Plan	Actual	Var
Elective	5,574		
Non-Elective	60,676		
Daycase	43,418		
Outpatient	368,867		
A&E	158,149		
Other NHS Non- Tariff	1,835,796		
Other NHS Tariff	131,518		
Total	**2,603,999**		

TOTAL GROUP: INCOME AND EXPENDITURE

	Plan	Actual	Var
	£m	£m	£m
Elective	£18.01	£18.01	(£0.00)
Non Elective	£114.89	£114.89	(£0.00)
Daycase	£30.72	£30.72	(£0.00)
Outpatients	£46.12	£46.12	£0.00
A & E	£23.16	£23.16	(£0.00)
Other-NHS Clinical	£110.48	£108.10	(£2.39)
CQUIN	£3.79	£3.79	(£0.00)
Other Income	£55.25	£46.21	(£9.04)
Total Income	**£402.43**	**£391.00**	**(£11.43)**
Pay	(£268.59)	(£277.44)	(£8.86)
Drug Costs	(£42.41)	(£40.27)	£2.13
Clinical Support	(£27.63)	(£26.48)	£1.14
Other Costs	(£58.35)	(£62.67)	(£4.31)
PFI Costs	(£13.19)	(£13.36)	(£0.17)
Total Expenditure	**(£410.17)**	**(£420.22)**	**(£10.06)**
EBITDA	**(£7.74)**	**(£29.22)**	**(£21.49)**
Non Operating Expenditure	(£25.16)	(£24.98)	£0.17
Surplus / (Deficit) Adjusted*	**(£32.89)**	**(£54.21)**	**(£21.31)**
Conditional Funding (MRET/FRF/Top Up)	£33.35	£54.67	£21.32
Surplus / Deficit*	**£0.46**	**£0.46**	**£0.00**

* Adjusted to exclude items excluded for Financial Improvement Trajectory: Donated Asset Income, Donated Asset Depreciation and Impairments

DIVISIONS: INCOME AND EXPENDITURE

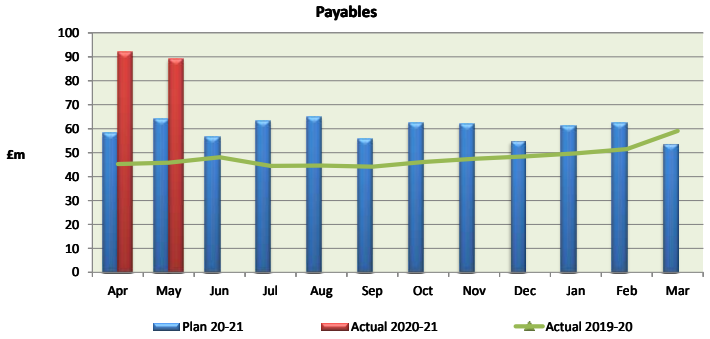
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£14.95	£20.14	£5.19
Medical	£44.08	£40.16	(£3.92)
Families & Specialist Services	(£7.03)	(£4.21)	£2.82
Community	(£1.92)	(£3.06)	(£1.14)
Estates & Facilities	£0.00	(£0.00)	(£0.00)
Corporate	(£43.21)	(£46.04)	(£2.82)
THIS	£2.31	£1.14	(£1.17)
PMU	£3.55	£3.55	£0.00
CHS LTD	£0.75	(£0.03)	(£0.78)
Central Inc/Technical Accounts	(£15.45)	(£9.23)	£6.22
Reserves	(£4.17)	(£4.34)	(£0.17)
Unallocated CIP	£6.62	£2.39	(£4.22)
Surplus / (Deficit)	**£0.46**	**£0.46**	**£0.00**

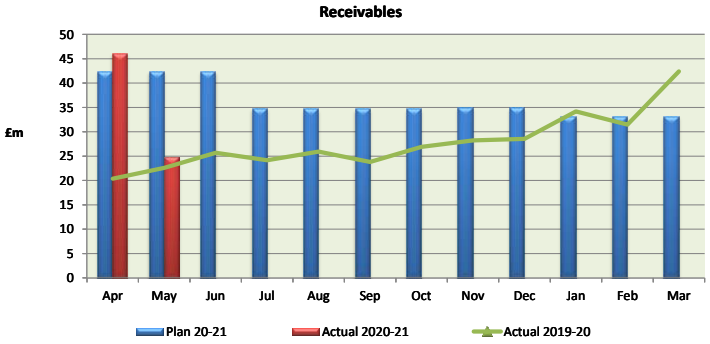
Total Group Financial Overview as at 31st May 2020 - Month 2

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO NHS IMPROVEMENT

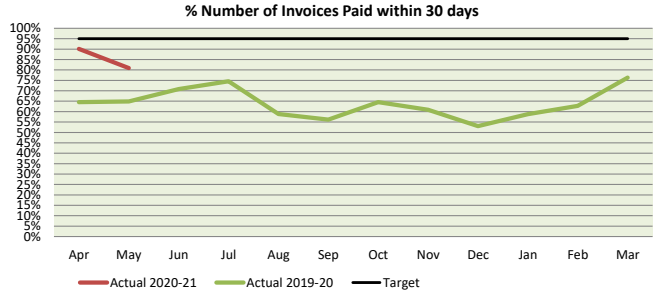
WORKING CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Payables (excl. Current Loans)	(£64.24)	(£89.14)	£24.90	
Receivables	£42.40	£24.92	£17.48	



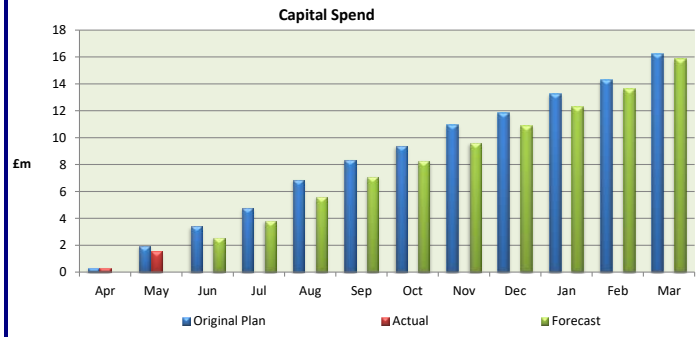


BETTER PAYMENT PRACTICE CODE



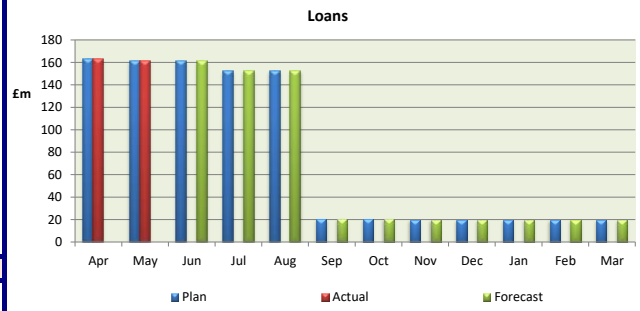
CAPITAL

	M2 Plan £m	M2 Actual £m	Var £m	M2
Capital	£1.92	£1.54	£0.38	

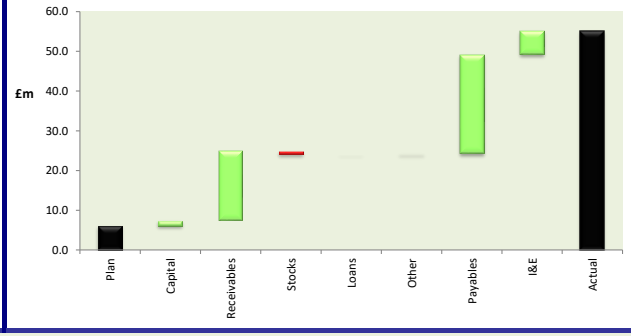


CASH

	M2 Plan £m	M2 Actual £m	Var £m	M2
Cash	£6.05	£55.19	£49.14	
Loans (Cumulative)	£161.70	£161.70	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The Trust's own financial plan for 2020/21 has been replaced by an NHSI derived plan which assumes a breakeven position will be achieved for at least the first four months of the financial year. Income flows are largely on a block basis and Covid-19 costs are funded retrospectively. Year to date the position is at breakeven after assumed receipt of £5.80m of retrospective top up funding.
- Clinical Contract income is in line with the NHSI Interim plan due to new fixed block and top up arrangements. The assumed 'Retrospective Top Up' of £5.80m accounts drives a favourable variance in overall Clinical Income, offset to some extent by lower than planned income from other sources including private patients.
- Year to date activity is well below plan for all points of delivery as a result of the Covid-19 response.
- The Trust has incurred £6.83m in relation to Covid-19, of which £2.36m relates to gowns which were purchased by the Trust on behalf of the region.
- Year to date Capital expenditure was lower than planned at £1.54m against a planned £1.92m.
- Cash balance is £55.19m, £49.14m above plan: payments for June's Block and Top Up received in advance and £10m bonus Financial Recovery Funding (19/20)
- No interim Revenue loans or PDC were required in month.
- Year to date CIP schemes have delivered £0.64m of savings, £1.82m lower than planned.
- NHS Improvement performance metric Use of Resources (UOR) stands at 2 against a planned level of 3. The Trust's Internal Plan was for a deficit position year to date, where as the interim NHSI Plan is for a break-even position, improving the overall UOR.

NOTES

- The Forecast assumes that the Trust will continue to receive sufficient funding to achieve a break-even position. The forecast position shown includes a planned gain on disposal of £0.46m, (assumed excluded for the purposes of FRF).
- The Forecast position assumes that the Trust's underlying deficit and ongoing costs relates to Covid-19 will be supported by either a continuation of the current Block and Top Up arrangements (as per the Interim Plan) or Financial Recovery Funding as per the Draft Plan submission / internal Trust plan.
- The Trust is forecasting Agency expenditure of £3.84m, considerably below the NHSI ceiling of £8.82m, but offset by an increase in expenditure on Bank staff.
- The Trust is forecasting delivery of £8.52m savings against a Trust CIP plan for 20/21 of £14.77m.
- The Trust is not planning to borrow during this financial year due to changes in the cash regime and planned Financial Recovery Fund / Top Up payments that should bring the Trust to a break-even position.
- The total loan balance at year end is forecast to be £19.88m as planned. All Revenue and Interim Capital Loans (totalling £140.72m) are expected to be either repaid or replaced by PDC funding by 30th Sept 20.
- Capital expenditure is forecast at £15.87m, £0.34m lower than the recently resubmitted 20/21 Capital Plan due to a reduction in costs relating to reconfiguration, offset to some extent by additional Covid-19 related expenditure.

RAG KEY: (Excl: UOR)
- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per NHSI risk indicator).

RAG KEY: UOR
- All UOR metrics are at the planned level
- Overall UOR as planned, but one or more component metrics are worse than planned
- Overall UOR worse than planned

INTERIM FORECAST

M1-4 20/21

	Plan	Forecast	Var	
	£m	£m	£m	
NHS Clinical Income	£114.40	£113.44	(£0.96)	
Other Clinical Income	£2.30	£1.72	(£0.59)	
Other Income	£16.22	£13.99	(£2.23)	
Total Income	**£132.92**	**£129.15**	**(£3.77)**	
Pay	(£89.01)	(£92.61)	(£3.60)	
Drug Costs	(£6.12)	(£5.67)	£0.44	
Clinical Support	(£8.77)	(£9.70)	(£0.93)	
Other Costs	(£29.07)	(£31.68)	(£2.60)	
PFI Costs	(£4.40)	(£4.45)	(£0.06)	
Total Expenditure	**(£137.37)**	**(£144.11)**	**(£6.74)**	
EBITDA	**(£4.45)**	**(£14.96)**	**(£10.51)**	
Non Operating Expenditure	(£8.30)	(£8.48)	£0.17	
Surplus / (Deficit) Control Total basis*	**(£12.75)**	**(£23.44)**	**(£10.70)**	
Total Forecast Top Up	£12.74	£23.44	£10.70	
Surplus / Deficit*	**(£0.00)**	**(£0.00)**	**£0.00**	

*Adjusted to exclude items excluded for Control Total purposes: Donated Asset Income, Donated Asset Depreciation and Impairments

Forecast Top Up

Forecast Top Up required	M1	M2	M3	M4	Total
	£'m	£'m	£'m	£'m	£'m
Planned Top Up	£3.19	£3.19	£3.19	£3.19	£12.74
Retrospective Top Up	£3.39	£2.41	£2.63	£2.27	£10.70
Total	£6.57	£5.60	£5.82	£5.46	£23.44

Covid-19 costs and the ongoing impact of the current situation on activity and income have been assessed for M3 and 4 and a retrospective top up of a similar scale to that required in M2 is forecast for the next couple of months. Pending further guidance on M5-12, the forecast assumes that the Trust will continue to receive CCG clinical income at current block levels, that Covid-19 costs and activity levels will remain at a broadly similar level to those seen in M2 and that the Trust will continue to have access to some sort of top up funding in future months to bridge the financial gap. Work to assess future capacity and the cost of delivering services based on current infection prevention and control guidance is ongoing but is not yet sufficiently progressed to accurately inform the financial forecast at this stage.

Key Variances:

- Covid-19 costs for the next two months are estimated to be circa £2.4m per month. This includes additional PPE costs of £0.8m per month for gowns (regional) and masks, Covid-19 testing costs of £0.3m per month and additional staffing costs of at least £0.5m per month. Further costs will also be incurred for the hire of additional mobile scanners, for estate modifications and the segregation of patient pathways.
- The Trust will continue to lose income relating to Car Parking, Catering and Private Patients estimated at £0.4m per month.
- These losses will continue to be offset to some extent by lower consumables expenditure in some areas as planned activity is expected to remain well under plan.
- Pay costs are likely to increase in future months as many Covid-19 requirements remain, but most redeployed substantive staff will return to their usual areas in support of reset plans.

The estimated forecast retrospective top-up value includes an increase of £0.29m per month in relation to a shortfall in non-clinical care income. This is following clarification from NHSI that non-clinical CCG income in relation to the provision of Health Informatics Services should be covered by the CCG block funding and cannot therefore be recovered from CCGs in addition to this. This now results in a shortfall against the NHSI derived plan for non-clinical care income which requires an increase in the retrospective top-up in order to achieve a break-even position.

COVID-19

Revenue Impact of Covid-19 - YTD MAY 2020					
Division	**Annual Leave Accrual**	**Covid-19 Direct Costs**	**Impact on activity**	**Loss of Income**	**Total**
	£	£	£	£	£
Central & Technical	0	4,017,705	208	0	4,017,913
Medicine	0	1,308,209	(413,575)	0	894,634
Families & Specialist Services	0	368,270	(49,381)	163,780	482,669
Calderdale & Huddersfield Solutions Ltd	0	281,555	(8,500)	14,750	287,805
Corporate Services	0	86,654	0	533,234	619,888
Community	0	256,543	0	12,139	268,682
Health Informatics	0	42,550	0	0	42,550
Surgery & Anaesthetics	0	462,091	(872,198)	0	(410,107)
NHS Nightingale (Hosted Costs)		3,264			3,264
Total costs identified	**-**	**6,826,841**	**- 1,343,446**	**723,903**	**6,207,298**
Retrospective Top Up requested					**5,796,511**

Capital Impact of Covid-19 - MAY 2020	
Details	**Covid-19 Costs**
	£
NPEX (PDC received)	330,000
Equipment	444,686
Asset Tracking	105,422
Total costs identified	**880,108**
PDC Confirmed	**330,000**

The Trust has incurred Covid-19 direct costs totalling £6.827m as shown in the table and these have been reported to NHSI in support of the requested 'Retrospective Top Up'.

Key areas of spend are as follows:
Pay - £2.243m

Reported Covid-19 costs are the 'net cost' and represent the additional staffing costs incurred due to the Covid-19 response and do not include the cost of substantive staff that have been redeployed into expanded capacity areas. Pay costs relating to the Covid-19 response were primarily linked to the requirement for existing staff to work additional shifts, in particular over the Easter Bank Holiday weekend which coincided with a peak in the number of Covid-19 cases across the two hospitals. There were also significant additional costs incurred as a result of increased shifts in community services with most staff working the April bank holidays and additional shifts to support 7 day working which have continued into May. Almost 150 students (nursing, therapies and medical) have been added to the payroll, some of which have been working in a supernumerary capacity. Changes to medical rotas also had a financial impact with additional enhancements paid to junior medical staff. Increased substantive costs were offset to some extent by a reduction in agency and bank costs and lower than planned pay costs in some non Covid ward areas where bed occupancy was lower than usual.

Non Pay - £4.580m

Clinical Supplies costs linked to Covid-19 were £0.91m, including costs related to increased ICU capacity of £0.18m, £0.35m on Covid testing and £0.12m on CT scanner hire.
Other non pay costs attributable to Covid-19 totalled £3.67m but included the full cost incurred for the purchase of gowns (PPE) on behalf of the whole region (£2.36m). The remaining £1.31m includes other PPE costs of £0.74m (masks, additional scrubs, respirators etc), additional equipment, minor works for social distancing / segregation and patient transport.

Nightingale Hospital - £0.003m
The Trust has not accounted for any costs relating to the Nightingale hospital in Month 2.

Income Losses

In addition, the Trust has lost income totalling £0.72m due to loss of Car Parking Income, (£0.43m which is a combination of income from staff permits and income from patients and visitors), loss of catering income (£0.06m), loss of apprentice levy income (£0.04m from pausing of HCAs apprenticeships delivered internally) and loss of private patient income (in particular from Yorkshire Fertility).

These costs have been offset to some extent year to date by the indirect impact of lower than planned costs in non-Covid areas where activity has reduced as a result of the Covid-19 response.

Capital funding for Covid-19 costs has also been requested as shown. The Trust is waiting for confirmation of PDC funding to cover most of this additional expenditure.

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	2nd July 2020
Meeting:	Board of Directors
Title:	Annual report (April'19-March'20) from the Guardian of safe working hours, CHFT
Author:	Anu Rajgopal
Sponsoring Director:	David Birkenhead
Previous Forums:	none

Actions Requested:
To note

Purpose of the Report

To provide an overview and assurance of the Trust's compliance with safe working hours for junior doctors across the Trust and to highlight and detail any areas of concern

Key Points to Note

1. Increase in the rota gaps in paediatrics with a consequential increase in Exception Reports
2. An update of the Trust's compliance with the revised 2016 TCS implementation timescales
3. Ongoing progress with improving junior doctors working lives at CHFT in accordance with the BMA fatigue and facilities charter,

EQIA – Equality Impact Assessment

The medical workforce is ethnically diverse and exception reports submitted by our junior doctors have been split by ethnicity and gender. The analysis shows that the data is representative of the junior doctor population in the Trust.

Recommendation

The Board is asked to:

1. Note and approve the report
2. Continue to support the DME and GOSWH in improving compliance against the BMA Fatigue and Facilities charter
3. Note updates regarding the Trust's compliance with revised 2016 TCS timescales
4. Acknowledge the hard work and dedication of our trainees in supporting a new rota over the COVID-19 pandemic

Annual report: (1st April 2019 to 31st March 2020)

Guardian of safe working hours (GOSWH), CHFT

Executive summary

This paper will update the Trust board on issues relating to safe working hours of doctors in training and provide assurance that junior doctors at CHFT are safely rostered and enabled to work hours that are safe.
The period of cover is from April 2019 to March 2020

A total of 114 exception reports (ERs) have been submitted, majority from junior trainees. I am pleased to note that there has been a notable improvement in the time to resolution of ERs which should lead to improved engagement of our junior doctors with the exception reporting process.

Paediatrics has seen a big increase in exemption reporting which reflects the significant rota gaps present in that speciality. There was successful recruitment of Trust doctors in Medicine in Q3 which was followed by a consequential decrease in exception reports in comparison with surgery. Rota gaps still persist in the Emergency department who moved on to a new 3-tiered rota pattern in August'19 in order to address these gaps. Vacancies across specialities were covered mostly by bank staff and the number of unfilled shifts has shown a decrease this year, especially in Surgery.

The Trust has signed up to the BMA's fatigue and facilities charter to improve the working lives of our trainees at CHFT. In consultation with junior doctor representatives, it was agreed to spend the £30,000 allocated to CHFT as part of the above on refurbishing existing mess facilities at both sites. This is near completion now and will open after ensuring that the area is COVID secure and appropriate risk assessments and signage have been completed.

Our colleagues in Medical HR have worked extremely hard to ensure that the Trust is on track with the revised 2016 TCS junior doctor contract and will be compliant by August 2020.

There has been a welcome improvement in trainee engagement with the junior doctor forums this year. CHFT held its inaugural Junior doctor awards in May 2019 which was well supported by the Trust executive team and received fantastic feedback from our trainees.

Essential data

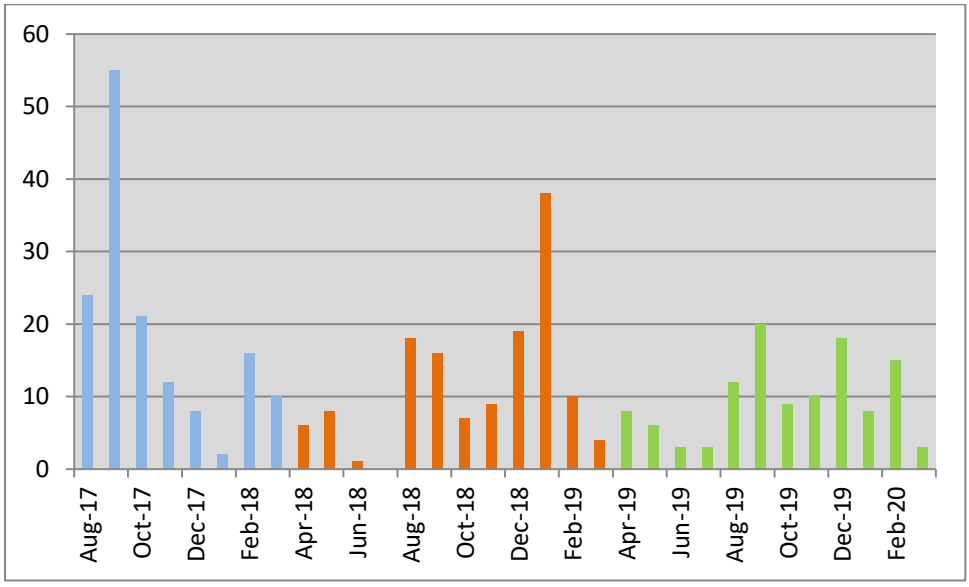
FY1 doctors in post	**46**
FY2 doctors in post	**39**
Core trainees	**30**
GPSTR at CHFT (not including GP practices)	**31**
Speciality trainees	**88**
Training post vacancies	**12**

a) **Exception Reports**

Total number of exception reports received per quarter this year

	Immediate safety concerns	Total hours of work and/or pattern	Educational opportunities/ support	Service support available	TOTAL
Q1	0	17	0	0	17
Q2	0	33	1	1	35
Q3	0	36	0	0	37
Q4	**0**	**23**	**1**	**2**	**26**
Total	**0**	**109**	**2**	**3**	**114**

Number of monthly exception reports (2017-current)

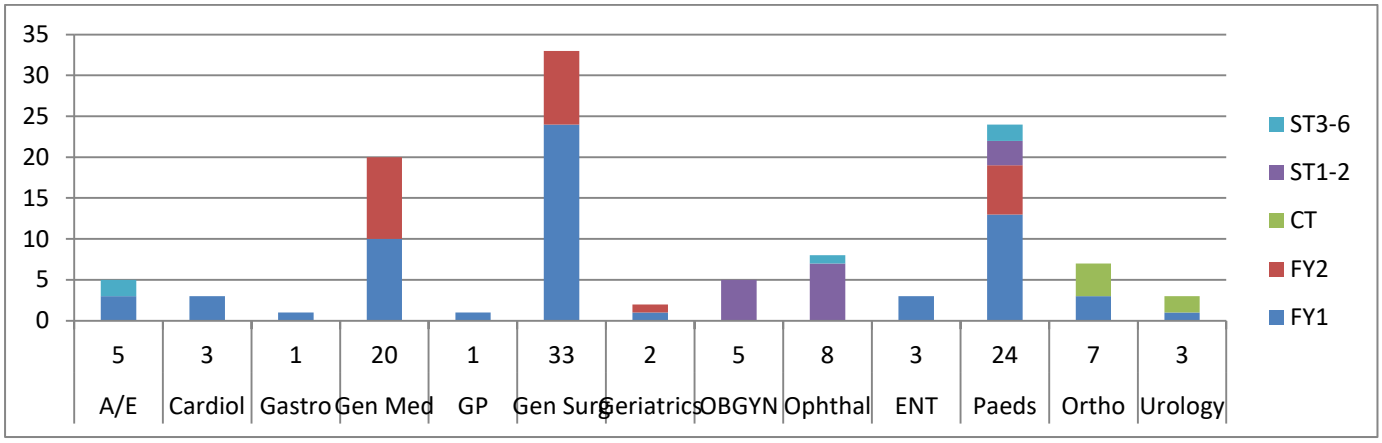


Trends in Exception Reporting

There have been a total of 114 exception reports (ERs) from 38 junior doctors representing only sixteen percent of all doctors on the 2016 TCS. Majority of these (96%) were from junior trainees with only five ERs from ST3-ST6 grades. There is a spike seen with increased exceptions reported soon after the new FY1 induction in July and then during the winter months reflecting a busy period in the hospital.

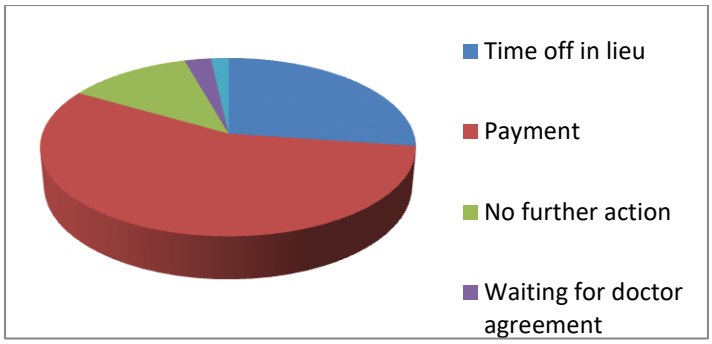
Locally, our first hospital cases of COVID-19 started presenting in April ’20 and exception reports over this period will be reported in my Q1 report for 2020-21.

This year, there has been a substantial decrease in ERs from the medical division (23% of total ERs) and an absolute increase in reports submitted from Paediatrics, accounting for one fifth of ERs submitted. Majority of these were from foundation year and junior trainees. There were eight ERs submitted in Ophthalmology, seven of which were from the same trainee and reported over Q1 and Q2. This was in contrast to none being reported from this speciality in 2018-19. All these were reported due to the over-running of the emergency eye clinic. This was highlighted to the clinical lead and effective procedures were put in place to sort the issues raised. There was lack of clarity around exception reporting within the department which was addressed by a GOSWH presentation at the audit meeting.



Type of exception and outcome:

As seen in previous years, majority (96%) of exceptions are due to excess hours worked suggesting that overworking is common and is an element of reporting that doctors are more comfortable with. It is likely that the ER system is not appropriate for reporting lack of rest and missed natural breaks. There were only 2 related to a missed educational opportunity, both a single occurrence and not leading to any work schedule review. Over 94% of ERs have been completed within the recommended timescale which is a significant improvement over previous years. The table below illustrates the outcomes.



There is an improvement in the quality of ER reviews with supervisors leading to a higher rate of those resulting in no further action or being compensated with time taken off in lieu.

b) Rota gaps and areas of concern (See Appendix)

Specialities with significant rota gaps are Emergency medicine, Paediatrics and Orthopaedics.

A/E: A high number of registrar grade gaps persist in A/E due to deanery gaps and inability to recruit. There were 2 new trust doctors and 3 ACPs who started in Q3. The A/E rota was revised from August 2019. In the new format, the rota is split into three new rotas per site (ST4+/Speciality Dr, ST3/FY3, and FY2/GPST/CT/ACP). This seemed to be working better and there are fewer registrar-level gaps. The vacancies are covered by locums and ACPs when needed.

Paediatrics: Paediatrics has significant gaps at registrar grade which are likely to increase due to further maternity leave. At present the ACPs cover some of these and the rest are covered by locums out of hours. Two trust grade doctors were employed in Q4 to help with the vacancies on the junior rota. One full time agency locum was trialled for a month on the registrar rota but it didn't work out.

Trauma & Orthopaedics: there are three trust grade vacancies (junior grade) which have been filled but the COVID-19 pandemic has delayed the start date. There is only one deanery gap at the registrar level which is covered by bank staff.

Medicine: A few ERs had flagged up very busy on-call shifts on weekends. From Aug'19 the rota has been revised with extra weekend day-time cover provided and a more equitable distribution of weekend on-call. There is also an additional gastro on-call consultant at HRI. Divisionally, there is a weekly medicine rota meeting including registrars and trust grade doctors and a monthly junior doctor meeting to further discuss any rota issues, vacancies and recruitment. An additional registrar overnight has been requested and this is currently being discussed with the trainees.

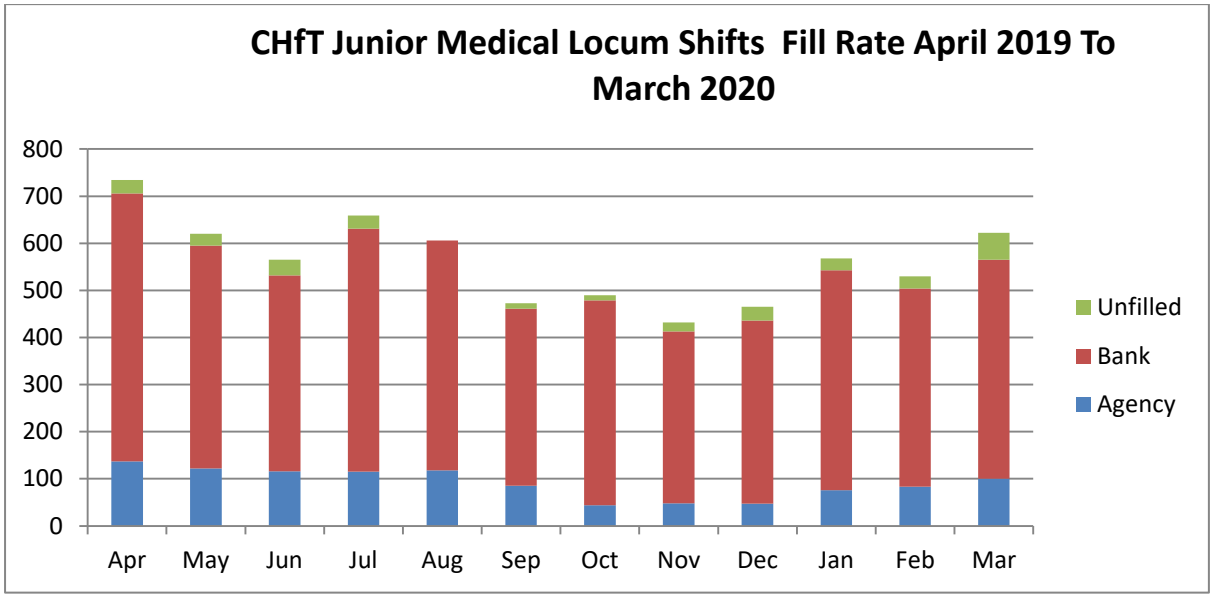
Anaesthetics have a couple of vacancies on the registrar rota with a further gap anticipated from August 2020. These will be covered by bank staff.

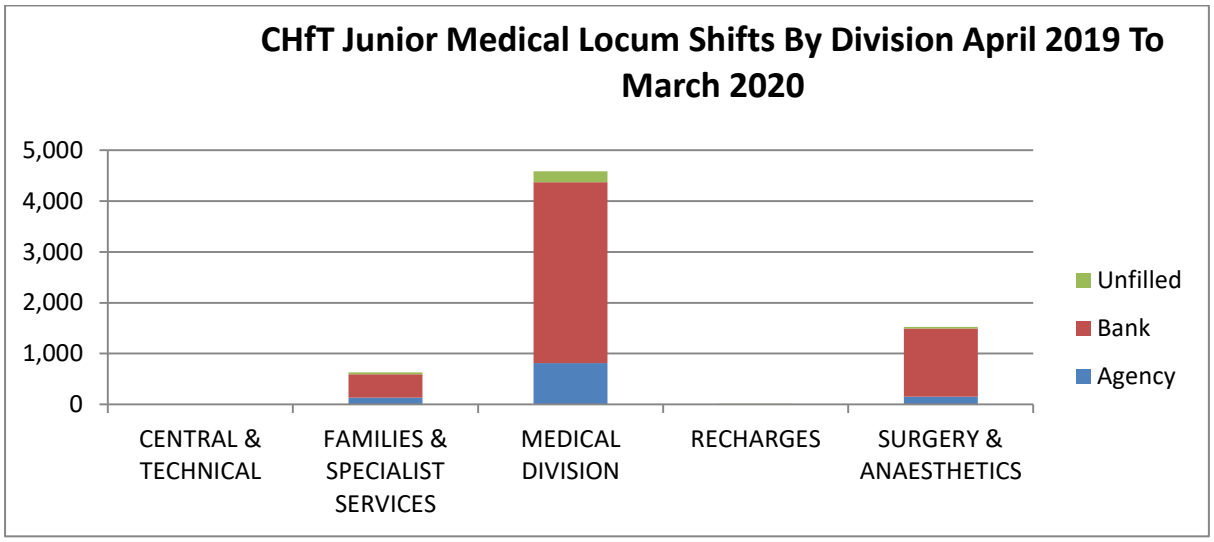
General surgery: there is only one gap at the registrar grade, none at foundation level and the vacancy at the CT grade has been recruited into. For both Urology and ENT, there is a long-term registrar gap (deanery gap and maternity leave) which is covered out of hours by locums. There were 2 vacant Urology Trust doctor posts which now have been successfully filled.

c) Work schedule reviews

There have been none this year

d) Locum bookings





Compared to the previous year, the number of unfilled shifts has decreased especially in surgery which is a good trend and contributes to the well-being of our junior doctors. Bank shifts have increased relative to agency locums which is also a positive trend. Better tracking of doctors hours is required when doing bank shifts as it is likely that locum hours will cause breaches in working time if done in addition to normal working hours. Doctors themselves have a responsibility and duty of care for regulating their own hours of working, in addition to the organisation.

e) Immediate safety concerns

None

f) Fines levied

No fines have been levied this year

Guardian money

Following support at the JDF, some of the GOSWH fine money was used in Q3 to present vouchers to all junior doctors working in the Trust on Christmas day as a token of our appreciation. This has been very well received.

g) Other relevant issues this year

i. Implementation of the revised 2016 TCS

In 2018 NHS Employers undertook a review of the 2016 contract and a number of recommendations were made and agreed by the BMA in June 2019. A staggered implementation of agreed changes commenced in August 2019. The Trust is on track to be fully compliant by August. An implementation timescale was completed in Q4 to ensure that any changes that are needed are done collectively with the appropriate individuals and that we apply an inclusive approach with our Junior Doctors. Medicine is the only rota that needs finalising; all the rest have been created and agreed to date.

ii. BMA fatigue and facilities charter

CHFT had signed up to the charter with the DME as nominated lead supported by the medical director, GOSWH and Medical HR. It was agreed at the junior doctor forum that the £30,000 allocated to CHFT will be spent to improve the mess facilities at both HRI and CRH. Refurbishment of these sites is nearly complete. However, in-line with the UK government's guidance on social distancing and reducing the risk of COVID-19 transmission, the mess areas will now need the relevant risk assessment and signage. I will feedback on progress later in the year.

iii. Post-shift rest facilities for junior doctors

This was raised by the BMA representative. The revised 2016 TCS states that Trusts were already required to cover the cost of an appropriate rest facility or alternative arrangements for the trainee's safe travel home and will now also provide for reasonable expenses to be paid for the trainee's return journey to work, either to begin their next shift or, where they have left their personal vehicle at work, to collect the vehicle.

At CHFT we do have rest facilities available. However if these are full, there is no clarity on the process for booking and payment for alternative facilities and no baseline figures on how often this happens. The CHFT board supported this in Feb'20 and we have been given some hotel booking options if trust accommodation is unavailable. The process has to be drafted and communicated to our junior doctors. This will be a piece of work that we need to do in 2020.

iv. Engagement with the exception reporting process

A Junior doctor poll in Oct'19 (40 responders) highlighted that further work is required to improve engagement and this is confirmed on reviewing the trends in exception reporting above where only 16% of the junior doctor body has exception reported in 2019-20. I have already raised awareness around exception reporting at induction days and departmental audit days. I will continue to do that on a rolling programme next year and will get some GOSWH slots at the trainee forums.

v. Impact of COVID -19

The JD Planning COVID-19 group was set up in March 2020 via Microsoft teams. Members included the junior doctor representatives, the deputy medical director, the DME, divisional reps, medical HR and rota coordinators. The GOSWH was also added to this later. This group served as an excellent communication platform during the pandemic. HEE sent out notification in March'20 to say that all trainees will not be rotating in April 2020 and will remain in their current placements until further notice/guidance is issued. This will not impact on their ARCP later on in the year. Junior doctor rotas were modified and put into place in April 2020 and I will feedback on that in my next quarterly report.

h) Junior doctor forum (JDF)

Trainee attendance and engagement at the JDF has improved compared to previous years.
Majority of the issues raised were around improving junior doctors working lives at CHFT: Increasing availability of computers in wards and offices (escalated within divisions), adequate time given in work schedules to update portfolios and complete mandatory training (Medical education and HR are aware and dedicated time has been allocated), improving catering options and facilities (some improvements were made), provision of confidential waste bins in handover rooms (resolved).
These will be reviewed as part of our compliance with the BMA charter. Progress against it will be monitored through the JDF.

i) Junior doctor awards

The first ever CHFT junior doctor awards were held in May 2019 with awards given to doctors in training across 6 categories and one supervisor award. This was really well supported by our executive team and was a huge success with positive feedback from trainees and supervisors.

j) Support for guardian role

Amount of time available in job plan for guardian to do the role: 1 PA/week

Admin support provided to the guardian (if any): adhoc support provided by medical HR

Amount of job-planned time for educational supervisors: 0.125 PA per trainee

Amount of job-planned time for clinical supervisors: None

Summary

Whilst relatively few junior doctors exception report, the information gained regarding their working lives is extremely valuable and the feedback of this information to divisions and specialities should help support improvement and change in the workforce. Vacant posts continue to produce significant problems for junior doctors in terms of workload. This is particularly highlighted by the increase in the number of exception reports from paediatrics. Work is ongoing to improve the junior doctor mess and agree a clear process on accessing post-shift rest facilities when required.

Recommendations

- Continue to support the DME and GOSWH in improving our compliance against the Fatigue and Facilities charter
- To note the update regarding the Trust's compliance with the revised 2016 TCS timescales
- Acknowledge the hard work and dedication of our trainees in supporting a new rota over the COVID-19 pandemic

The board is requested to receive and note this report.

Anu Rajgopal
Guardian of safe working hours
June 2020

Appendix: Rota Gaps

Period	Grade	Gaps	Reason	Cover	Vacancy period	Anticipated gaps
Medicine						
Apr– Oct'19	ST4-7	5/2 LTFT	Deanery	Locums	Feb – Oct 2019	No
Oct'19-Mar'20	ST4-7	1 LTFT	60% LTFT	Locums	Oct 19 - Sept 20	Trust Registrars recruited
April - March 20	FY1/FY2/CMT/GPS	1 LTFT	60% LTFT	Locum	Apr -Mar'20	No
April - March 20	FY1/FY2/CMT/GP	1 LTFT	50% LTFT	Locum	Apr -Mar'20	No
Gen Surgery						
April – Aug 19	CT1-2	1	Deanery	Locum	Feb – Aug 2019	No
Apr– Aug 2019	CT	1	Trust	Locum	Feb – Aug 2019	Advert out
Jul – Oct 2019	ST3+	1	Mat leave	Locum	July – Oct 2019	No
Urology						
Apr– Oct 2019	ST3+	1	Deanery	Locum	Feb – Oct 2019	No
Oct'19-Apr'20	ST3+	1	Deanery	Locum	Oct'19 –Apr'20	No
Apr'19-Mar'20	Middle grade	2	Trust	Locum	Apr'19 – Mar'20	Recruited into both posts
ENT						
Apr1'9 – Oct'20	ST3+	1	Deanery	Locum	Apr'19 – Oct '20	No
Paediatrics						
April – Aug'19	ST4-7	5	Mat leave	Locum	Feb – Aug 2019	No
Aug'19- Feb'20	ST4-7	4.5	Mat leave	Locum	Aug 19- Feb 20	Advertised for trust Dr
Feb – Aug '20	FY2-ST3	3	Mat leave	SAS	Feb – Aug 20	No
Feb – Aug '20	ST4-7	5	Mat leave	Locum	Feb – Oct 2019	No
OBGYN						
April- Aug '20	ST3+	1	Trust Gap	Locum	April-Aug 20	No
A/E						
Apr-Aug'19	FY2/GPST/CT	0.5	LTFT	Locum	Feb – Aug'2019	
	Speciality Doctor	3		Locum	Upto Aug'19	Rota changed
	ST3+	5	Deanery	Locum	July 2019	Rota changed
Sep'19-Apr'20	ST3/FY3	7	Deanery /Mat	Locum	Aug –Sep 2019	New rota(3 tiered)
	ST4+	4	deanery maternity	Locum	September 2019	
	FY2/GPST/CT	0.5	LTFT	ACPs	Aug-Sept 2019	
	FY2/GPST/CT	0.5	LTFT	ACPs	Aug'19 – Feb'20	
	ST3/FY3	8.5	Deanery/Mat	Locum	Aug'19 – Feb'20	
	ST4+/Sp.Doctor	4	Deanery/Mat	Locum	Sep'19 – April 2020	
Orthopaedics						
Apr'19- Aug 19	CT1-2	1	Deanery	Locum		N/A
Apr'19 - Aug 19	Trust grade	4	vacancy	locum		2 trust grades start Aug 19
Apr'19 - Oct '19	ST3+	1	Deanery	locum		N/A
Aug'19 – Feb'20	Trust grade	4	vacancy	locum		1 trust grade from Feb'20
Feb'20 - Aug 2020	Trust grade (FY/CT Level)	3	Trust vacancy	locum		3 trust grades were appointed. Unable to start due to COVID-19
Anaesthetics						
HRI 2nd on rota	SAS, ST3+	1	Vacancy	locum	June 2020	1more gap from Aug'20
CRH 1st on rota	SAS, MTI,CT	1	Vacancy	locum	June 2020	1more gap from Aug'20
CRH 2ndon rota	SAS	0.5		locum	July19 –	

Calderdale and Huddersfield NHS Foundation Trust

COVER SHEET

Date of Meeting:	Thursday 2nd July 2020
Meeting:	Board of Directors (Public)
Title:	Fire Action plan update
Author:	Helen Barker
Sponsoring Director:	Helen Barker
Previous Forums:	Content developed from Fire Committees

Actions Requested:
The Board is asked to note the current position, highlight any assurance concerns that require immediate action and agree to receive the Trust Strategy on completion.

Purpose of the Report

To provide an update on the actions required to maintain fire safety presented to the Board of Directors in April and May 2019. The update also highlights key issues as a Consequence of COVID19 for Board awareness

Key Points to Note

- The action plan is progressing with 2019/20 estate works completed to plan
- An alternative to ward decant and further compartmentation is currently being
- designed
- Fire training compliance is in line with expected performance and Fire Warden
- numbers have significantly increased.
- There are increased risks in relation to storage as a consequence of COVID19
- There is a need to increase involvement of the Fire Officer in stabilisation & reset
- Planning
- Fire Officer capacity is a concern
- A Fire Safety Strategy has been commissioned

EQIA – Equality Impact Assessment

There are several factors in relation to equality impact that must be considered within the Trusts management of fire and associated risks. These include support for staff, patients and public in the event of evacuation; support to staff working in more isolated facilities and the access to appropriate training. Issues are currently managed on an individual basis by the Fire Officer and relevant manager. The Trust has commissioned the production of a Fire Safety Strategy that will include a full Equality Impact Assessment.

Recommendation

That the Fire Committee continues to progress with delivery of the action plan, manage the ongoing risk mitigations as a consequence of COVID19 and receive the Fire Safety Strategy prior to presentation for approval to the Board of Directors
It is also recommended that the Board accepts the deferral of a full EQIA until produced with the Fire Safety Strategy

Calderdale and Huddersfield NHS Foundation Trust

Boards of Directors Fire Safety update

2nd July 2020

This paper provides an update on the action plan presented to the Board of Directors in April 2019 and updated in May 2019.

Progress continues on the majority of actions with some complexities as a consequence of increasing bed demand pressures at HRI and more recently the overall impact of COVID19 across CHFT.

A Fire Committee has been established, chaired by the Board Director responsible for Fire, and meets regularly. It's core responsibilities are to provide oversight, to ensure progress on previous actions and to review and manage risk. At the onset of COVID19 the committee undertook a detailed review of all COVID19 related risks and develop a specific risk, with mitigations on the COVID19 register. This repots into the Trust Health & Safety Committee

Action Plan update

The following table provides an update on actions previously agreed

Action	**Update June 2020**
Fire compartmentation survey – instruction through P22 contract (April19)	19/20 agreed fire compartmentation completed 60 min compartmentation survey complete
60-minute compartmentation rectification commences (June-December 19)	19/20 agreed fire compartmentation completed
30-minute compartmentation is rectified as part of the Estate Plan following the 6-facet survey	Survey completed and recommendations for 20/21 capital programme developed. Key constraint is the ability to decant wards due to ongoing non elective pressures and lack of decant facility. Alternative options have been explored with the installation of Dry Risers recommended. This is currently in design phase with the external supplier
Routine checks are made to minimise the amount of equipment left on ward corridors (ongoing)	Continue to be challenges with volume of equipment compounded by competing demands for storage. An off site solution for storage is being explored
New sockets have been provided at CRH and HRI to enable electronic equipment to	Sockets on both sites have been installed It is important to note that this does not take the charging out of the corridors

Calderdale and Huddersfield NHS Foundation Trust

be charged away from corridors	completely but minimises this and associated clutter so helps keep the corridors clearer.
Fire safety training package is agreed and on ESR	Complete however important to note that the booklet is being used this year due to Covid19 constraints
Fire safety training % figures improve	At the end of May 2020 the figure was 92.1% which is in line with Trust target percentage
A fire warden is available in each department and ward for every shift	Fire wardens are rostered onto all ward and clinical departmental shifts. Concerns raised in Acre Mill outpatients where Fire Wardens unclear on role when fire alarm activated. Specific further training completed and tested. During COVID, with significant changes in staff deployment, bespoke training was provided to support new rosters. Where gaps are identified additional training is instigated and there are two generic sessions per month, 1 at HRI and 1 at CRH Some issues highlighted in areas where the majority of staff are now working from home leaving some lone workers onsite in offices. Areas identified and process established to ensure staff inform of their presence on arrival and departure
The number of fire wardens increases	Trained Fire warden numbers continue to increase with 693 staff now trained, up from 334 previous year.
Fire training needs assessment is completed	TNA completed however delivery plan not yet agreed. Will require additional investment into Fire Team capacity which is currently being explored along with learning from COVID19 to establish alternative modes of delivery
Protected time is made available for clinical staff to do their mandatory and essential training (this is much wider than fire training)	Included as a recommendation in a Staff Survey paper going to BOD in July 2020. If approved this will commence in August 2020.
Question in Staff Survey- "I know what to do in the event of a fire" (Sept 19 survey)	This was not included in 2019 Staff Survey but plans in place to include in 2020 Staff Survey. Conversations are taking place nationally to decide whether the 2020 survey will still go ahead.
Fire drills take place	Drills continued up to COVID but are currently paused. Drills completed included Elland, Acre Mill OPD and PMU

	The Fire Officer has been involved in planning for alternative uses of areas as part of COVID planning and regularly undertakes walkrounds of facilities as additional safety checks and enabling discussions with colleagues around Fire safety To note. The loan Store and Poplars are now not Trust properties
Fire safety communications plan is developed	Communications are sent based on need either a proactive alert to changing guidance or reactive to issues. For example recently communications were sent about Alcohol Gel, both in terms of its flammability and the storage of it, such as in your car when it is hot weather. Discussions are ongoing with regard to overall CHFT Communications plan following learning from COVID19. Fire will be included as an area for discussion
Managers understand which staff, and why, are not attending fire training	Managers monitor via ESR supplemented by regular updates from HR Business Partners. Attendance continued to improve when face to face. Now moved to booklet as part of COVID19 response
Toaster sockets at HRI	Complete and the fire alarm activations are down by 50%
Fire activations	Areas are visited across the Trust to both understand the reason for the activation and if possible find ways to help and reduce the causes. Some issues with Hydrogen Peroxide Vapour (HPV, deep clean) as have caused regular activation. Working with Cleaning teams to identify actions to reduce incidence. Some issues with CRH kitchen activation that are being worked through with Engie.

In addition to the action plan previously agreed the Fire Committee is concerned about the robustness of the Fire Risk Assessment process and associated actions. This is currently a focus of the committee and a more comprehensive assessment will be provided with the next Board progress report.

The Trust currently only has 1 Fire Officer who has increasing demands on his capacity including all training, planning advice to estates and operational teams and oversight of risk assessments as well as day to day fire oversight. With the development of the reconfiguration plans for both HRI & CRH there will be further demands for CHFT Fire Officer input. A review of capacity, resilience and succession planning is underway

Calderdale and Huddersfield NHS Foundation Trust

COVID19 Fire implications

COVID Specific risks were reviewed in detail as part of COVID planning, the following are worth noting by the Board:

The Fire Officer should be consulted on all re-designation of areas as part of Stabilisation and Reset to ensure all fire risks known and mitigated. This Fire Officer notification remains variable and will now be included in the stabilisation and reset check list.

Some changes to estate were made in response to COVID19 e.g. segregated AEDs. These changes were signed off by the Fire Officer as temporary solutions but require further review to determine the efficacy for more long term deployment.

Storage is an increasing risk with both PPE and the need to remove seating etc as part of social distancing guidelines. Currently ward areas and the Old Laundry are at capacity and a cause for concern. A proposal to install a lift at the new facility in Elland has been submitted as part of the regional capital plan, this will allow the decant of a significant volume and reduce this risk.

Increased use of Oxygen, which was a core clinical response to COVID19, increased the risk of fire. Wards were identified following advice from the Fire Officer, increased walkround by the Fire Officer took place and oxygen usage was reported daily into Tactical. This risk is significantly reduced with Oxygen use back to pre Covid19 levels

New staffing rosters, particularly in outpatients where numbers have decreased, requires greater focus on fire wardens and this is being reviewed as part of Stabilisation and Reset.

A specification has now been agreed for Mott MacDonald to develop a fire Strategy for the Trust, this was initially delayed due to concerns around the completeness (was initially proposed just as a HRI Fire Strategy) and more recently due to visitor restrictions on site. This is now being progressed and will facilitate a Fire Policy review and a Trust Strategy.

Summary

Progress has been made on the action plan previously presented to Board, overseen by the Fire Committee. Covid risks were identified and effectively managed but some concerns remain about the completeness of stabilisation and reset planning in relation to fire and storage is a significantly increased risk.

The Fire Committee in place is providing greater scrutiny on all fire related issues and has improved reporting lines for assurance and escalation. There is a single Fire officer for the Trust which is a risk in relation to resilience, capacity to adequately support colleagues and input to future plans

The Trust requires a comprehensive Fire strategy to inform future planning, this is in progress.

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 2 July 2020
Meeting:	Board of Directors
Title of report:	GOVERNANCE Report
Author:	Jackie Ryden, Corporate Governance Manager
Sponsor:	Andrea McCourt, Company Secretary
Previous Forums:	None

Actions Requested:

- To note

Purpose of the Report

To inform the Board of documents for which the corporate seal has been applied, provide updates relating to governors and the 201920 Annual General meeting and board business – workplan and meeting dates for 2021 -22.

Key Points to Note

a) Use of the Trust Seal

The Trust Seal has been used twelve times since the last report to the Board on 7 November 2019 as detailed below, with the register of each sealing enclosed detailing further information at appendix 1.

The Board is asked to **NOTE** the use of the Trust Seal for the following items:

2019/20
12/19 Renewal lease for Park Valley Mills
13/19 Disposal of 14 – 24 Acre House Avenue
14/19 Acre Mill Land
15/19 Glen Acre House and Car Park transfer for freehold purchase

2020/21
1/20 Revised Location plan for Allan House for community staff
2/20 Deed of guarantee Shawbrook Bank
3/20 Sale of freehold land – Glen Acre House
4/20 Sale of The Poplars
5/20 Sale of Freehold Land – Glen Acre Car Park Plot
6/20 Lease Agreement for Outpatient Pharmacy at Calderdale Royal Hospital
7/20 Lease Agreement for Outpatient Pharmacy at Huddersfield Royal Infirmary

b) Governor Update

it is usual for the Trust to undertake its governor election process to replace governors who have reached the end of their tenure period between April and July. The election process was planned but had not been finally signed off when the Covid-19 pandemic arose. National advice was that governor elections should not be held during the pandemic as this would not be a democratic process. The Trust therefore wrote to the governors who were due to reach the end of their tenure in July 2020 to request if they wished to extend their role as a governor for a further year, from July 2020 to July 2021.

There were 5 public and 3 staff governors whose tenures were due to end. The Chair wrote to all 8 governors explaining the situation and all chose to remain as a governor for further year.

A list of those governors who have agreed to remain as governors for a further year and their constituency are given below:

CONSTITUENCY	NAME	DATE APPOINTED
PUBLIC		
3 – South Kirklees	John Richardson	15.9.17
5 – Skircoat and Lower Calder Valley	Brian Richardson*	18.9.14 15.9.17
6 – East Halifax and Bradford	Paul Butterworth	15.9.17
7 – North and Central Halifax	Lynn Moore*	18.9.14
7 – North and Central Halifax	Alison Schofield	15.9.17
STAFF		
9 - Drs/Dentists	Dr Peter Bamber	15.9.17
11 - Management/ Admin/ Clerical	Linzi Jane Smith	15.9.17
13 – Nurses/Midwives	Sian Grbin	15.9.17

*served two tenures of 6 years

c) 2019/20 Annual General Meeting (AGM)

A Trust Annual General Meeting cannot be held until the annual accounts for the year have been laid before Parliament. Changes by NHS England/Improvement in the annual report and account processes for 2019/20 in response to the Covid-19 pandemic were made which delayed the timeline for the accounts, with no guidance received until 5 June 2020 on the details for laying accounts before Parliament.

Consequently, the Annual General meeting planned for 15 July 2020 was postponed, with a date to be confirmed once the date for laying the accounts before Parliament was clear. A provisional date for the Annual General Meeting has been agreed for Wednesday 7 October 2020 from 5-6.30pm and this will be a virtual meeting rather than a meeting held in public for the safety of the public. Arrangements for holding the Annual General Meeting will be confirmed on the Trust website.

d) Board Workplan 2020-2021 including Annual Reports schedule

An updated Board workplan for 2020-21 is enclosed as Appendix 2. Any amendments to this should be notified to the Corporate Governance Manager.

e) Board Development Sessions 2020/2021
As agreed at the Private Board on 4 June 2020, the Board Development Sessions have been re-introduced. The first session was held on 22 June 202 focussing on Leading One Culture of Care. Two further dates have been scheduled 6 August 2020 to focus on Cyber Security and 10 September 2020 which will be a Quality Masterclass.

f) Board Meeting Dates 2021-2022
The dates for the public Board meetings for 2021/22 are attached at Appendix 3.

EQIA – Equality Impact Assessment
The holding of an Annual General Meeting via virtual means rather than in a public venue may adversely affect accessibility by those people who do not have access or the ability to use the IT required for such a meeting. However, a virtual meeting could encourage people from protected groups to attend the meeting from their own home.
Recommendation
The Board **NOTE** the use of the Trust Seal detailed in the paper, the governor appointments and changes to the AGM in response to the Covid-19 pandemic, and the Board meeting dates and workplan.

APPENDIX 1

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS November 2019 – March 2020

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
12-19	4.11.19	4.11.19	**Renewal lease for Park Valley Mills** Renewal lease for Park Valley Mills where the Trust current house community midwives and Child Health teams. The lease has been agreed following negotiations between Tom Donaghey (CHS on behalf of the Trust), Park Valley Huddersfield (Landlord) and Trust legal representatives Capsticks. The lease is for 5 years with a tenant break at Year 3, and has an initial rent of £13335 per annum.	NAME: Helen Barker TITLE: Chief Operating Officer NAME: David Birkenhead TITLE: Medical Director
13-19			**Disposal of 14 – 24 Acre House Avenue** The underleases are to be signed to allow the disposal of 14-24 Acre House Avenue properties which were sold at auction on 23rd October 2019 for a combined total of £670k. The properties are leasehold between CHFT and the local authority. This leasehold will be under leased to the purchaser. The lease has an initial rent of £100k per annum.	NAME: Ellen Armistead TITLE: Director of Nursing NAME: Amber Fox TITLE: Corporate Governance Manager

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
14-19	2 December 2019	2 December 2019	**Acre Mill Land** This lease is in relation to Trust owned land at Acre Mills which is currently being occupied by The Old Wireworks Pub (Landlord El Tel Pub Company Ltd). The agreement is currently undocumented and there is no income to the Trust. Tom Donaghey (CHS on behalf of the Trust) has been liaising with the pub landlord to agree a lease which protects the Trust interest in the land. A rental figure of £3744 per annum has been agreed with Stuart Baron (Associate Director of Finance). Trust legal representatives have been Capsticks. The lease is for 7 years which sits in-line with El Tel Pub Company's lease with the brewery. Termination of the lease can be served at any stage of the term with 3 months' notice which protects CHFT for any future use of the land. The lease is also excluded from the landlord and tenant act.	NAME: Helen Barker TITLE: Chief Operating Officer NAME: Andrea McCourt TITLE: Company Secretary

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
15-19	17 December 2019	17 December 2019	**Glen Acre House and Car Park** Transfer for the freehold purchase of Glen Acre House and car park area. This is required to allow the disposal of the sites and to maximise the sale value. The £50k asking price was negotiated using the district value and also Gary Boothby and the Director of Finance for the Council. The transfer is due to complete on Wednesday 18th December 2019.	NAME: David Birkenhead TITLE: Medical Director NAME: Andrea McCourt TITLE: Company Secretary

CALDERDALE & HUDDERSFIELD NHS TRUST: REGISTER OF SEALING OR EXECUTIONS 1 April – 19 June 2020

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
01-20	17 February 2020	31 January 2020	See 6/19 - Lease of Allan House for community division clinics. Revised Location plan for Allan House for community staff as per document from Hempsons, Manchester	NAME: Ellen Armistead TITLE: Executive Director of Nursing NAME: David Birkenhead TITLE: Executive Medical Director
02-20	9 March 2020	9 March 2020	Deed under Section 106 of the Town and Country Planning Act 1990- relating to land at Acre House. This deed forms part of the grant of planning permission for Acre House, securing the provision of affordable housing due to the scale of development. The Trust have obtained planning permission on the site to increase land value from approximately £850k to offers in excess of £1m. The Trust will be disposing of Acre House with the benefit of planning permission and the signed deed will be transferred to the purchaser.	NAME: Ellen Armistead TITLE: Executive Director of Nursing NAME: Andrea McCourt TITLE: Company Secretary

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
03-20	25 March 2020	25 March 2020	Sale of Freehold Land – Glen Acre House The documents include a contract, transfer of part registered title and a plan. The sale has been agreed previously at WEB and sale valued agreed with Chief Executive and Executive Director of Finance. The documents and plan to be signed. The transfer is due to complete before 31 March 2020.	NAME: Suzanne Dunkley TITLE: Executive Director of Workforce & Organisational Development NAME: David Birkenhead TITLE: Executive Medical Director
04-20	25 March 2020	25 March 2020	Sale of freehold land – The Poplars. The documents include a contract, transfer of part registered title and a plan. The sale has been agreed previously at WEB and sale values agreed with the Executive Director of Finance following independent market evaluations.	NAME: Suzanne Dunkley TITLE: Executive Director of Workforce & Organisational Development NAME: David Birkenhead TITLE: Executive Medical Director

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
05-20	30 March 2020	30 March 2020	Sale of Freehold Land – Glen Acre Car Park Plot The documents include a contract, transfer of part registered title and a plan. The sale has been agreed previously at WEB and sale values agreed with the Director of Finance following independent market valuations. The sale documents also include a Pre-emption agreement for the sale of Lindley GP to the same buyer, as part of negotiations between Gary Boothby, Stuart Baron, Stuart Sugarman and the CCG.	NAME: Suzanne Dunkley TITLE: Executive Director of Workforce & Organisational Development NAME: David Birkenhead TITLE: Executive Medical Director

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
06-20	14 May 2020	14 May 2020	**Lease Agreement for Outpatient Pharmacy at Calderdale Royal Hospital** These agreements relate to the outpatient pharmacy dispensaries at CRH. The current provider Well Pharmacy gave notice to terminate its occupation for May 2020 and procurement and pharmacy department have been leading on a tender for a new provider and have been successful in appointing Rowlands. This project has been lead by Lis Street and has gone through WEB and a number of other forums. The new leases will replace the Well Pharmacy lease following the deeds of surrender which were signed last week. Bevan Brittan have acted for the Trust in the drafting of the lease and negotiation with Rowlands.	NAME: Helen Barker TITLE: Chief Operating Officer NAME: David Birkenhead TITLE: Executive Medical Director

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON	PERSONS ATTESTING SEALING OR EXECUTION
07-20	14 May 2020	14 May 2020	**Lease Agreement for Outpatient Pharmacy at Huddersfield Royal Infirmary** These agreements relate to the outpatient pharmacy dispensaries at HRI. The current provider Well Pharmacy gave notice to terminate its occupation for May 2020 and procurement and pharmacy department have been leading on a tender for a new provider and have been successful in appointing Rowlands. This project has been led by Lis Street and has gone through WEB and a number of other forums. The new leases will replace the Well Pharmacy lease following the deeds of surrender which were signed last week. Bevan Brittan have acted for the Trust in the drafting of the lease and negotiation with Rowlands.	NAME: Stuart Sugarman TITLE: Managing Director Calderdale and Huddersfield Solutions Limited NAME: David Birkenhead TITLE: Executive Medical Director

	Public	Public	Public	Public	Public	Public
Date of meeting	**7 May 2020**	**2 July 2020**	**3 Sept 2020**	**5 Nov 2020**	**14 Jan 2021**	**4 March 2021**
Date of agenda setting/Feedback to Execs	2 April 2020	4 June 2020	5 August 2020	5 October 2020	7 December 2020	1 February 2021
Date final reports required	28 April 2020	23 June 2020	21 August 2020	23 October 2020	4 January 2021	19 February 2021
STANDING AGENDA ITEMS						
Introduction and apologies	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	✓	✓	✓	✓
Chair's report	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓
Integrated Performance report (Inc: Quality, Finance, Workforce)	✓	✓	✓	✓	✓	✓
REGULAR ITEMS						
Board Assurance Framework	✓		✓		✓	
Calderdale Huddersfield Solutions Managing Directors Report	✓		✓	✓	✓	✓
Climate change Sustainability Report			✓			
Director of Infection Prevention Control (DIPC) quarterly report (See annual items)	✓	✓ Q1			✓	
High Level Risk Register	✓	✓	✓	✓	✓	✓
Learning from Deaths – Quarterly Report			✓ Q2	✓Q3		✓ Q1
Guardian of Safe Working Quarterly Report		✓Q1		✓Q2	✓Q3	
Quality Board update	✓	✓	✓	✓	✓	✓
Staff Survey Results		✓		✓		✓
Nursing and Midwifery Staffing Hard Truths Requirement			✓ (Bi-annual)			✓ (Bi-annual)
Safeguarding update – Adults & Children			✓ (Annual report)			✓
Financial Update	✓	✓	✓	✓	✓	✓
Performance management update		✓	✓	✓	✓	✓

Health and Safety Update	✓		✓	✓		
Service Reconfiguration Outline Business Case						✓
CX report – Calderdale Care Closer to Home Alliance (AB) TBC						
COVID-19 Update	✓	✓	✓	✓	✓	✓
MINUTES FROM SUB-COMMITTEES						
Quality Committee update & Minutes	✓	✓	✓	✓	✓	✓
Audit and Risk Committee update & Minutes	✓	✓	✓	✓	✓	✓
F&P Committee update & Minutes	✓	✓	✓	✓	✓	✓
Workforce Committee update & Minutes	✓	✓	✓	✓	✓	✓
Charitable Funds Committee Minutes	✓	✓	✓	✓	✓	✓
COVID-19 Oversight Committee	✓	✓	✓	✓	✓	✓
GOVERNANCE REPORT						
Standing Orders/SFIs/SOD review	✓					
Non-Executive appointments			✓	✓		✓
Board workplan		✓	✓	✓	✓	✓
Board skills / competencies					✓	
Board meeting dates		✓			✓	
Committee review and annual reports		✓				
Annual review of NED roles			✓			
Use of Trust Seal		✓		✓		
Declaration of Interests - BOD (annually)						✓
Attendance Register – (annually)	✓					
BOD Terms of Reference						✓
Sub Committees Report & Terms of Reference	✓					✓
Constitutional changes (+as required)	✓					
Compliance with Licence Conditions	~~✓~~ ARC June					
Assurance (Quality) Visits Feedback (on hold due to Covid-19 pandemic)		~~✓~~		✓ TBC		✓ TBC

ANNUAL ITEMS						
Annual Plan						✓
Capital Plan					✓	
Council of Governors Elections (notification of revised arrangements)		✓				✓ (timetable)
Infection Prevention Control Board Assurance Framework		✓				
Digital Health Strategy		✓		✓		
Emergency Planning Annual Report			✓			
Fit and Proper Person Self-Declaration Register						✓
Guardian of Safe Working Hours Annual Report	✓	✓Annual				
HPS Annual Report	✓		✓Annual			
Health and Safety Annual Report			✓Annual	✓ (update)		
Guardian of Safe Working Annual Report		✓				
Public Sector Equality Duty (PSED) Annual Report						✓ (Annual Report)
DIPC Annual Report (ALSO SEE REGULAR ITEMS)			✓ (Annual Report)			
Fire Safety Annual Report		✓ (Annual Report)				
Audit & Risk Committee Annual Report 2019/20			✓			
Finance & Performance Committee Annual Report 2019/20			✓			
Quality Committee Annual Report 2019/20			✓			
Workforce Committee Annual Report 2019/20					✓	
Medical revalidation & appraisal Annual Report			✓)			
Freedom to Speak Up Annual Report – delegation request to Workforce Committee		✓				✓ (Annual Report)
Review of Board Sub Committee TOR - TBC						
Risk Appetite Statement			✓			

Risk Management Strategy					✓	
Winter Plan			✓	✓		
Workforce OD Strategy						✓

Appendix 3

Public Board of Directors Meetings Dates
Proposal for 2021-2022

Date	Time	Location
Thursday 6 May 2021	9:00 – 12:30 pm	Huddersfield Royal Infirmary
Thursday 1 July 2021	9:00 – 12:30 pm	Calderdale Royal Hospital
Thursday 2 September 2021	9:00 – 12:30 pm	Huddersfield Royal Infirmary
Thursday 4 November 2021	9:00 – 12:30 pm	Calderdale Royal Hospital
Thursday 13 January 2022	9:00 – 12:30 pm	Huddersfield Royal Infirmary
Thursday 3 March 2022	9:00 – 12:30 pm	Calderdale Royal Hospital

Bank Holidays 2021
2 April
5 April
3 May
31 May
30 August

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Monday 4 May 2020, 11.00am – 12.30pm Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Stuart Baron	Associated Director of Finance

ITEM

046/20 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting held via Microsoft Teams.

047/20 APOLOGIES FOR ABSENCE

Apologies were received and noted for Andrea McCourt, Helen Barker, and Sian Girbin.

048/20 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

049/20 MINUTES OF THE MEETING HELD 2 MARCH 2020 AND 30 MARCH 2020

The Minutes of both the Public and Private meetings held 2 March 2020 and the Minutes from the meeting held 30 March 2020 were all approved.

050/20 ACTION LOG AND MATTERS ARISING

088/19: RTT Final Close-down Report – The Chair asked for confirmation of a realistic date to be scheduled for the review of the close-down report and to update the action log accordingly – **HB/BS**

009/19: Use of Resources (UOR) Update – The Deputy Director of Finance reported that internal Task & Finish Groups are proceeding where practical, however, those groups which require operational input have been withdrawn. It was noted that a repository for documents and evidence gathered has been established The Chair asked that consideration should be made regarding what would be required to put in place a realistic timetable to complete this piece of work with an update at the next meeting. It was also noted that KA would follow up with her counterpart at Bradford Royal Infirmary (BRI) following their recent CQC rating and their score of 'Good' for UoR.

ACTION: To review the requirements to put in place a realistic timetable for completion ,including external review, and to contact BRI to discuss learnings from their recent UoR rating – **KA, 1/6/20**

FINANCE & PERFORMANCE

051/20 MONTH 12 FINANCE REPORT INC. FINANCE RISKS

The Director of Finance reported that following significant movement in Month 12, the year-end reported position was a surplus of £0.05m, a £9.76m favourable variance from plan. This includes additional incentive Financial Recovery Funding (FRF) of £10.04m as notified on the 23 April 2020. It was noted that to achieve the funding CHFT had had to deliver our plan, it was also noted that the Integrated Care System (ICS) also delivered their plan. From a CHFT point of view both our local Commissioners achieved their plans which supported a view that our contract value was broadly in line with plan prior to COVID-19. It was also noted that Month 12 was supported by COVID funding apart from our annual leave accrual which was not supported but became an allowable variation.

The key headlines from the paper were noted as follows:

- Delivered a surplus for 2019/20
- Delivered our CIP of £11m
- Agency expenditure for the year was below the planned level and significantly below the NHSI ceiling
- Overall, a positive performance

The Chair congratulated the Executive Team on achieving plan which has not been without its challenges.

The Chair also congratulated and thanked the Finance Team for their significant achievement to complete in line with the original timescale particularly under exceptional circumstances.

The Financial Risks were discussed in detail and the following Risk Scores were agreed by the Committee:

- Longer-term financial sustainability (added to BAF in February 2020) – **Remain at Risk Score 16**
- Not achieving the 2020/21 Financial Plan – **Risk Score 12**
- The Trust will have insufficient funding available to complete its capital programme for 2020/21 – **Risk Score 6**
- The Trust will not be able to pay suppliers, staff, and loans due to cash flow timing or an overall shortfall of cash – **Risk Score to reduce from 12 to 8**

It was also agreed that the Committee would keep all risks under regular review.

The Committee **NOTED** the Month 12 Finance Report and the Financial Risks

052/20 BUDGET BOOK

The Deputy Director of Finance highlighted the following key headlines from the more detailed report included in the papers:

Overview – the whole budget book has been completed on a 'Business as Usual' basis to provide a baseline to measure any variation to our business as usual plan prior to COVID-19. It was noted that this will help hold people to account where appropriate and it will help with submissions for COVID-19 funding support.

Income & Expenditure 20/21 Plan – This shows a pre-support financial deficit of (£27.48m) in line with our Financial Improvement Trajectory (FIT). Achievement of this deficit will allow us access to FRF totalling £27.48m, this will take the Trust to a break-even position. Receipt of FRF funding will be conditional on achieving the Trajectory on a quarterly basis, but will also in part be reliant on the system, as a whole, achieving its plan.

Further guidance has been received regarding the write-off of the interim revenue and capital loans, which is a notable change for next year (see Item 053/20 below). The impact of this is to bring the Trust back to a positive balance sheet position.

Planned Cashflow – Cash balances as at 31st March 20 were higher than planned, however, this does not include the £10m incentive FRF funding, partly due to being notified after planning closed and partly due to still needing to determine what expenditure plans this can support.

Capital Plan – the full Capital Plan will be subject to the ICS being able to manage within 85% of the total ICS plans and slippage will be re-balanced accordingly, this also applies to our internally funded capital plan. There is also a level of capital spend which we anticipate will be supported through the Public Dividend Capital (PDC) but this has not yet been confirmed.

PW asked if the Trust had come under any pressure regarding the reconfiguration business case. It was noted that conversations had taken place with NHSI/E colleagues and that it was agreed that we should continue with the process and not lose ground.

RH asked about the process to control and capture COVID costs, it was noted that the process is challenging, however, the whole of Management Accounts remain focussed on this piece of work. It was also noted that one-off costs are relatively easily managed, however, there are costs which require more judgement such as nursing and medical staffing, overtime and the procurement of consumables. In terms of how we balance the overall position it was acknowledged that we need to demonstrate an understanding and some control in order that we can justify central funding to bring us back to a break-even position. The complicated and additional work which is required by the Finance Team was acknowledged.

The Director of Finance reminded the Committee that versions of the Budget Book are circulated to Divisional teams as part of Divisional/Directorate level accountability.

The Director of Transformation & Partnership raised a question regarding the communication to Divisions of the CIP requirement quoted within the Budget Book. It was noted that colleagues within Finance and PMO are due to meet tomorrow to review the national guidance and this will be picked up and discussed at that point.

ACTION: To schedule time on the Work Plan to review Divisional Performance later in the year – **BS/KA**

The Committee **APPROVED** the detailed Budget Book.

053/20 CHANGES TO THE FINANCE REGIME

The Director of Finance provided the Committee with a detailed paper describing recent changes to the NHS cash regime. It was noted that the full guidance of which had been issued since the 20/21 Financial Plan was approved by Finance and Performance Committee.

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

054/20 PROJECT ECHO UPDATE

The Associate Director of Finance presented a paper which provided an update on the position of the Project Echo PFI restructuring project and the implications of the deferral of IFRS 16. It was noted that the technical and legal aspects of the negotiations are all but concluded. From a commercial perspective, the key outstanding matter is the finalisation of the split of the gainshare, this is currently proposed at 70/30 in the Trust's favour. It was also noted that the Trust continues to negotiate a greater share of the gain, however, the negotiation on gainshare will not be concluded until the approvals are received from DHSC and Treasury. The Trust continues to have fortnightly update calls to understand where the approval of the transaction is within NHSI/E, DHSC and Treasury and the latest timeline received was suggesting September 2020 being the completion date for this transaction.

It was recognised that the deferral of IFRS 16 to April 2021 is likely to have a significant adverse I&E impact on this transaction as the new accounting standard created the Trust greater flexibility and liaison with NHSI/E and KPMG is on-going. Discussions continue with regulators to ensure that this does not become a barrier to agreeing the transaction.

The Committee **NOTED** the progress and position of the PFI restructuring including the change in accounting treatment and potential to delay the project whilst this issue is resolved.

055/20 PERFORMANCE UPDATE

The Assistant Director of Performance explained that the report is not in the usual format, however, most of the data has been collated.

It was noted that CHFT have performed well this financial year and our performance for March 2020 was 71.3% which is a slight improvement on the previous month despite the current COVID situation. In addition, a number of indicators have been impacted by COVID and it is estimated that actual year-end performance would have been 73.1% under normal circumstances.

It was also noted that CHFT have benchmarked extremely well nationally, when the 2 key metrics (Emergency Care and 62 day Cancer) are considered together and we are placed 3rd out of 115 acute organisations.

COVID-19

In terms of the impact of COVID our existing performance standards will remain in place, however, the way these are managed will need to change for the duration of the COVID response and the report included a detailed list of the metrics affected. In response, a COVID Knowledge Portal+ has already been developed and a Ward Activity model has also been developed to include a number of quality indicators

which can be tracked by site and time period, this will be developed further to ensure we do not inadvertently cause harm to any of our patients. In addition, discussions are due to take place shortly to review the safe opening of routine referrals.
It was noted that Recovery Workstreams have been established and a dashboard has been produced to look at the initial set of key indicators, from an outpatient point of view, to ensure there is no slippage on individual patient pathways.

It was also noted that there will be more focus on outcomes in terms of the IPR moving forward and this will develop over the next few weeks.

The Chair congratulated the Executive team and colleagues who have supported them in terms of the impressive full year performance particularly considering the current COVID situation. It was also noted that the real time data available from the Knowledge Portal is impressive and helpful to both Executives and Non-Executives.

The Chief Executive commented that our success with our benchmarking over the last few years should be communicated and celebrated Trust-wide. It was also noted that COVID-19 and the established data sets available could provide the Trust with the opportunity to start developing internal targets, for example, the ratio of deaths to discharge. Therefore, we should start conversations with clinical colleagues to understand what those internal targets should be and to review the system-wide position.

ACTION: To establish discussions with clinical colleagues to agree internal targets and to review the overall system-wide position – **PK to include OW and David Birkenhead in discussions**

ACTION: To monitor the development the IPR and to review the outcomes of the Recovery Workstreams at this Committee – **PK/HB**

ACTION: To revisit the historical targets we have failed to meet to review and determine realistic targets going forward– **PK/HB, date to be confirmed**

The Committee **NOTED** the positive full year performance.

056/20 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Draft Capital Management Group held 11/3/20
- Draft Cash Committee held 16/4/20

057/20 MATTERS TO CASCADE TO BOARD

The following headlines were noted to cascade to Board:-

- Month 12 Financial Position
- Budget Book approval
- Changes to the financial regime
- IPR Performance for March and full year including the national rating on the key indicators

058/20 REVIEW OF MEETING

It was felt that the meeting had been helpful, not only a financial review but an opportunity to receive an operational update.

059/20 ANY OTHER BUSINESS

The Chief Executive pointed out that according to the mortality portal on the standard Knowledge Portal we are now showing 222 deaths for April and that this is the second highest month since our records were created (Jan 2009=237). This is summer and really is a strong indicator that we might need to bring forward our winter planning for a future F&P discussion sooner rather than later.

ACTION: To schedule our Winter Planning discussion earlier than we would normally on the Workplan for F&P – **HB/BS, review timing for the Workplan.**

DATE AND TIME OF NEXT MEETING:
MONDAY 1 June 2020, 11am – 2pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on Monday 1 June 2020, 11.00am – 1.00pm Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance - In part
Philip Lewer	Chair

OBSERVING

Yusuf Abhura	Graduate Finance Trainee

ITEM

060/20 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting which included Yusuf Abhura, Finance Graduate Trainee who was observing the meeting.

061/20 APOLOGIES FOR ABSENCE

Apologies were received and noted for Andrea McCourt, Helen Barker, and Sian Girbin.

062/20 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

063/20 MINUTES OF THE MEETING HELD 4 MAY 2020

The Minutes of the meeting held 4 May 2020 were approved as an accurate record.

064/20 ACTION LOG AND MATTERS ARISING

055/19: PRMs – The Assistant Director of Performance updated the Committee of conversations which are taking place to review the areas which we have not historically achieved – **action carried forward**.

009/19: Use of Resources (UOR) Update – The Deputy Director of Finance reported that we continue to hold Task & Finish groups where possible. It was noted that a conversation had taken place with Chris Smith, Deputy Director of Finance at Bradford Teaching Hospital Foundation Trust (BTHFT) regarding sharing information and data which they used for their UOR review. It was also noted that BTHFT engaged external advisors who carried out a mock UOR review, therefore, it was felt that this would be our preferred way forward and the next step will be to identify and approach the external advisor.

ACTION: To provide a timeline of the key actions for the next meeting and to increase the awareness and purpose for this work throughout the organisation using key forums to establish engagement and understanding – **KA, 29/6/20**

The Committee **NOTED** the update and agreed with the process, the involvement of the Executives and Non-Executive Directors was also acknowledged.

FINANCE & PERFORMANCE

065/20 PERFORMANCE UPDATE

Prior to the Performance Update, the Assistant Director of Performance took the Committee through the key headings on the proposed Divisional PRM Agendas which will be shared with the Executives for comment later today.

The Assistant Director of Performance reported that the Trust performance for April was 75.3% despite the current COVID situation. It was noted that some of the Efficiency indicators had improved in month due to the reduction in activity whereas Diagnostics 6 week waits, 28 day cancellations and 52 week waits had been adversely affected.

In terms of the indicator changes, it was noted that there will be a change moving forward into 2020/21 as Key Performance Indicators (KPIs) will need to be more recovery focussed. The suggested patient outcome KPIs will be shared at each Board sub-committee and within Divisional Boards before committing to a final selection.

With regard to COVID metrics, it was noted that CHFT has seen a sharper decrease in the number of confirmed cases since its peak when compared to West Yorkshire in general, this is even more apparent when compared to the BTHFT position. It was also noted that CHFT has the highest occupancy of non-COVID patients at 60% currently across WYAAT.

Peter Wilkinson, asked about the reason for the removal of the Friends & Family 'would recommend' indicator, it was noted that this was a national request which was planned for April, a different way of measuring this indicator is under review. It was also confirmed that the COVID comparator metrics are reliant on the information released by other organisations.

Following discussions, it was agreed that before any decision is taken regarding the indicators we decide as an organisation to monitor in the future, we need to undertake an EQIA on those indicators that we are proposing to are remove.

In terms of the finance indicators the Director of Finance commented that the challenge is to understand what the operating framework will look like for 2020/21. It was noted that the finance regime was on hold for 4 months but following receipt of recent correspondence this may now been extended to 12 months.

Additionally, the Director of Transformation & Partnerships suggested that with our rate and pace of implementing technology during the pandemic a 'digital' indicator should be included within the KPIs, for example monitoring the percentage of our outpatient consultations which are carried out virtually. In terms of our longer term

plan, the learning from the COVID situation will be to embed the positive changes and not revert to the way we operated.

ACTION: To review KPIs and ensure an impact assessment of indicators that will not be monitored is carried out – **PK**

Outpatient Reset Workstream Update
A presentation was shared with the Committee which outlined what expectations are both nationally and locally along with the challenges. It was noted that our current position is as follows:

- 2 week wait referrals are almost at pre-COVID levels and this is a priority for the organisation
- Not all referrals are triaged on receipt, which needs to be addressed
- Time allocated in job plans for clinical review, but not assured all patients are being reviewed
- Progress made for a flag for Shielded patients, however, a completion date is still tbc
- Capacity review by specialty suggests face to face maximum capacity is 30% of previous
- System Improvement Programme (SIP) established
- Capacity will be used on a needs-based assessment not time-based

The presentation also included a number of graphs showing the RTT Referral Rate and the RTT Incomplete Pathways for the Trust. The Committee were reminded that the Trust is still one of the pilot sites for average waits and we continue to measure our waits in that format. It was noted that there are weekly meetings being held to discuss the SIP which is attended by senior clinical leaders.

In terms of next steps:

- PRMs will confirm capacity and agree specialty prioritisation
- Review process for assurance of clinical validation and agree 'Active Monitoring ProtocOl'
- Continue weekly SIP meetings and then transfer into the Outpatient Transformation Programme.

The Director of Finance commented that at this point in time there would be many assumptions made whether it be around the availability of PPE or another COVID spike but one of the biggest assumptions will be what activity we can do for the rest of the year within the 'financial envelope'.

It was noted that prior to COVID, Healthwatch and CHFT, through the Outpatient Transformation Board had worked together to carry out an extensive patient survey regarding the use of technology. This is being re-visited post-COVID and another patient survey is being undertaken with Healthwatch to ask directly what patient experience has been and what are their views for the future. This survey is currently live, but a snapshot of the results so far has been positive.

It was noted that this Committee received an Outpatient Recovery Plan presentation earlier in the year and that this forum will require clarity with regard to how much of that existing plan will still be applied, what elements need to be taken out and what

new elements need to be incorporated. It was also noted that a clear Board sign-off with regard to the Outpatient Recovery aspects is required.

The Director of Transformation & Partnerships commented that within the Outpatient Recovery Plan it was highlighted that colleagues within the Outpatient department were receiving a number of calls relating to the booking/re-booking of appointments. It was noted that a fundamental review of the booking service will need to take place with either a centralised or devolved booking service whichever is the most efficient way of working for the individual specialties.

ACTION: To review the existing Outpatient Transformation Plan with the Outpatient Re-set to align and ensure Board sign-off is received – **HB/PK**

ACTION: To review further recovery workstreams in future meetings – **PK, ongoing**

The Committee **NOTED** the strong April performance.

066/20 MONTH 1 FINANCE REPORT

The Deputy Director of Finance reported that the focus of the Finance Report this month would be on COVID, the key headlines from the paper were noted as follows:

- We are being measured against a plan issued by NHSI, which assumes a breakeven position for the first four months.
- Income flows are largely on a block basis and COVID costs are funded retrospectively.
- The Month 1 position is at breakeven after assumed receipt of £3.0m retrospective top up funding.
- Whilst there is no expectation of CIP delivery, the Trust continues to deliver some savings as planned. CIP achieved year to date is lower than planned.
- Agency expenditure year to date is below the planned level and NHSI trajectory, however, there is an increase in the volume of bank usage.
- Our UoR rating which was planned as a 3 has tipped into a 2, this is purely due to the fact that we are at a breakeven position where we had planned to be in a deficit position.
- The Capital Plan is lower than the 'business as usual' plan, but the Plan has subsequently been re-submitted with a new profile to take into account the different operational circumstances and a lower overall Plan for the year to fit with the overall ICS capital total.
- At the end of April 2020 the Trust had a cash balance of £38.23m, £33.03m higher than planned. This cash balance was higher than planned due to the payment in advance of the May block commissioner contract and 'top up' payments.
- Aged Debt is £5.22m in month, a significant amount of that is with other NHS organisations.

It was confirmed that the purchasing costs for gowns will be claimed back as part of our COVID costs following an agreement which was reached with NHSI and other organisations.

The Director of Finance added that to get to the simplified position of 'breakeven' there is a complex procedure being undertaken with a vast industry in the background.

In terms of our submission for COVID costs and how we compare across WYAAT, it was confirmed that at first review we looked slightly higher, however, having now received the comparison from the whole of WYAAT, taking into account the scale of the organisation, we appear to be average and not a massive outlier. It was noted that we have received a query from NHSI regarding our pay bill, this is linked to our decision to ask colleagues to work the bank holiday and not all organisations made that decision.

A discussion took place regarding CIP and it was noted that Finance and PMO are working together to look at CIP efficiencies which could help with investment in other areas. It was suggested that we should look at changing the language from cost improvement to investment priorities. A review of the re-instatement of Turnaround Executive will also take place.

The Committee **NOTED** the Month 1 Finance Report.

067/20 CAPITAL PLANNING UPDATE

The Director of Finance informed the Committee that a request has been received to co-ordinate a 15% reduction in the overall capital programme at Integrated Care System (ICS) level. This does not include external funding such as the digital aspirant monies, only internally generated funding elements. The Trust has met the overall ICS request with minimal impact to our capital programme due in part to the sale proceeds of a property.

The Committee **NOTED** the reduction to the Capital Plan.

068/20 PROJECT ECHO UPDATE

The Director of Finance updated the Committee that it is expected that we shall receive Ministerial approval to allow us to progress to the next stage at some point this week. It was noted that there is still a lot of interest in the market, which was a concern with the impact of COVID. There is still an issue around the delay in adoption of the IFRS16 accounting standards flagged last month and this continues to be progressed and discussed with NHSI to find a solution.

The Committee **NOTED** the progress of Project Echo.

069/20 TERMS OF REFERENCE

The Chair presented the Terms of Reference for review and requested comments off-line from the Committee. These will be collated, and a revised set of Terms of Reference will be produced for ratification at the next meeting.

ACTION: To present a revised Terms of Reference document at the next meeting – **agenda item**

070/20 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Draft Capital Management Group held 12 May 2020

- Draft THIS Board held 22 April 2020 (both the February and March meetings were cancelled).

071/20 MATTERS TO CASCADE TO BOARD

The following headlines were noted to cascade to Board:-

- Use of Resources Update - timeline for key actions, including external review, to be developed.
- April Performance review - strong April with score over 75%; on-going work to update KPIs, with a greater 'outcomes' focus; review of COVID 19 KPIs against WYAAT showed steeper decline in COVID cases and higher non-COVID occupancy at CHFT
- Outpatients - presentation on 'service reset', with essential move away from face to face appointments due to social distancing, PPE constraints etc.
- Financial Performance Month 1 - achieved overall breakeven after block contract income and 'top up' payments to cover COVID 19 costs etc.
- Finance Other - Update on Capital Planning (£0.5m reduction overall for 20/21) and Project Echo

072/20 WORK PLAN 2020/21

The Work Plan will be reviewed prior to the next meeting by the Chair and the Committee Administrator.

073/20 REVIEW OF MEETING

It was commented that virtual meetings are working well.

074/20 ANY OTHER BUSINESS

There were no other matters to discuss.

DATE AND TIME OF NEXT MEETING:
MONDAY 29 June 2020, 11am – 2pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 16 June 2020 commencing at 10.15am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Gary Boothby	Executive Director of Finance
Kirsty Archer	Deputy Finance Director
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Clare Partridge	External Audit Partner, KPMG
Jackie Ryden	Corporate Governance Manager (minutes)
Alastair Graham	Non-Executive Director/Chair of CHS Limited
Owen Williams (items 5d-h)	Chief Executive
Zoe Quarmby	Financial Controller

OBSERVERS

Philip Lewer	Trust Chair

39/20 APOLOGIES FOR ABSENCE

Apologies were received from Salma Younis, KPMG Audit Manager.

The Chair welcomed everyone to the Audit and Risk Committee meeting and outlined how the meeting would be managed.

40/20 DECLARATIONS OF INTEREST

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

41/20 MINUTES OF THE MEETING HELD ON 7 APRIL 2020

The minutes of the meeting held on 7 April 2020 were approved as a correct record subject to the following amendments.

Treasury Management Report

- The Deputy Director of Finance presented an update on treasury management in 2019/20 and highlighted points to note in relation to the 2019/20 plans. This should read:
  The Deputy Director of Finance presented an update on treasury management in 2019/20 and highlighted points to note in relation to the 2020/21 plans.

- At the time of writing the report no guidance had been received on plans to write off historic revenue debt, but guidance has since been received that this will be written off. Information regarding the full detailed mechanism is awaited. This should read:

  but detailed guidance has since been received that this revenue borrowing along with Emergency Capital loans will be extinguished and converted to Public Dividend Capital. Remaining debt will comprise business as usual capital loans and PFI debt.

Review Waiving of Standing Orders

- New heading to be inserted above the second paragraph for Internal Audit Reports.
- RH commented that in the past progress on charitable funds had been highlighted. This should read: RH commented that in the past lack of progress on charitable funds had been highlighted.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 7 April 2020 subject to the above amendments.

42/20 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updated accordingly.

Matters Arising

27/20 Annual Governance Statement - At the meeting on 7 April 2020 it was reported that the Company Secretary advised that the Trust is planning to declare a significant control issue due to Covid-19 subject to any further national guidance that may be received. The Director of Finance advised that this is now not the case following national guidance.

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

43/20 ANNUAL REPORT AND ACCOUNTS

a) Going Concern Report

The Director of Finance presented the Going Concern report which concluded the accounts should be prepared on a going concern basis.

RH queried the use of the word indefinitely in the first paragraph in relation to the operation of an organisation. The Director of Finance advised that this is the same wording that has been used in previous years but that he will re-consider the wording for next year. The External Auditor confirmed she agreed with this approach.

CP pointed out that last year a disclaimer 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.

The Chair asked for clarification regarding the loans of £139m and how these reconcile to the £163m of DHSC loans shown in the accounts. The Deputy Director of Finance explained that at the time of writing a loan had been received for Q3 which was believed to be repayable of £2m but the Trust has subsequently been allowed to retain loan funding over the year end in support of the cash position. Since the time of writing the Going Concern Note it has been confirmed that this £2m will be part of the overall loan balance to be extinguished. The remainder of the balance to the £163m relates to capital loans which will remain as borrowing. As such the £139m quoted in the Going Concern Note needs to be amended to £141m. KPMG confirmed their agreement to this amendment.

The Director of Finance advised that the biggest constraint currently on capital is for the Capital Department Expenditure Limit (CDEL). A limit has been set for the Integrated Care System (ICS) which is very challenging as a number of organisations within the ICS, including CHFT, have the cash currently to make investments but are not allowed to breach CDEL.

OUTCOME: The Committee **NOTED** the Going Concern Report.

b) Audited Annual Accounts and Financial Statement

The Director of Finance reported that a positive performance was achieved.

The Director of Finance pointed out that CHFT delivered on the control total plan, with a surplus of £50k but the accounts show a deficit of £338k. This difference is due to the fact that the accounts are prepared on a slightly different basis to the control total so there are impairments and the impact of grants and donations within these figures.

RH had reviewed the accounts in detail and had no concerns to raise. He also added that this is a much better picture than has been seen over the last three or four years.

OUTCOME: The Committee **APPROVED** the Audited Annual Accounts and Financial Statements.

c) Letter of Representation

The External Audit Partner of KPMG reported that the letter of representation includes standard wording with the right to add additional comments. One specific representation has been added which is linked to the Electronic Patient Record (EPR) system, accounted for as an intangible asset.

RH pointed out that this is carried over from the previous EPR valuation when a prudent approach was taken. The External Audit Partner KPMG confirmed that it had been agreed to retain this approach and not make any change.

OUTCOME: The Committee **APPROVED** the Draft Letter of Representation.

d) Annual Governance Statement (AGS)

The Company Secretary reported that the Trust is declaring no significant control issues for 2019/2020. The Statement has been development in line with NHS Improvement (NSHI) national guidance including guidance on how to handle COVID-19. The reference to the Quality Accounts has been removed as that will be handled differently this year due to COVID-19. Consultation has included discussion with the Outer Core Directors, the Audit and Risk Committee meeting and members, has been approved externally with KPMG and is consistent with the Head of Internal Audit Opinion. There is just one further change to be made to the document relating to the numbers of finalised internal audit reports.
Action: Company Secretary to amend the Annual Governance Statement to reflect the updated internal audit report reports.

OUTCOME: The Committee **APPROVED** the draft Annual Governance Statement subject to the amendments to the internal audit reports.

e) Annual Report

The Company Secretary presented the Annual Report, which has been developed in line with the NHSI annual reporting manual. She explained that the guidance has changed several times. It is not necessary to include a section on performance analysis this year but CHFT has included this as it shows a positive position for the Trust. The Annual Report has been reviewed in detail prior to the meeting by the Audit Committee Non-Executive Directors and KPMG. Guidance has now been received on the process to lay the report before Parliament and it has been agreed to take the earlier option of using an e-laying process which will be simpler. This will be done in early July 2020 and it is intended this year to print a condensed version of the annual report, with the full report available on the internet. Once the accounts have been laid before Parliament, a new date will be scheduled for the Annual General Meeting**.**

RH advised that he had a number of queries regarding the Annual Report but will pick these up outside of the meeting with the Company Secretary. These relate mainly to the remuneration

report and pension tables. The External Audit Partner KPMG confirmed that these tables have been audited and she was happy with the details.

The Chair suggested that the section on the history of the Trust should include a note of the creation of Calderdale and Huddersfield Solutions Limited (CHS). The Company Secretary explained that the history related to service delivery from a patient perspective and that it would not be relevant to include a mention of CHS.

The Chair also suggested that it would be useful to show a comparison with the figures from last year for the Friends and Family test given that these are improved. The Company Secretary agreed to include further narrative about a comparative improvement.
Action: Company Secretary will add further narrative regarding the improvement in the Friends and Family Test.

It was noted that the Quality Account will include a detailed report on complaints and this has been referenced in the Annual Report.

OUTCOME: The Committee **APPROVED** the Annual Report.

f) Head of Internal Audit Opinion and Annual Report

The Internal Audit Manager presented the report for 2019/20 which is in support of the annual governance statement and is in the same format as last year. The opinion sets out the results for the internal audit service as performed throughout the year.

A total of 29 audits have been issued of which 27 reports have been finalised. A breakdown of the finalised reports is shown below:

- 2 – High Assurance
- 20 – Significant Assurance
- 4 – Limited Assurance
- 1 – Split Opinion (No Opinion / Significant Assurance)

The purpose of the annual Head of Internal Audit Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its AGS. The overall opinion is that:

Significant assurance can be given that there is a good system of internal control which is designed and operating effectively to meet the organisation's objectives and that this is operating in the majority of core areas.

It is noted that completion of the 2019/20 Internal Audit Operational Plan has been impacted since March 2020 as a result of COVID-19. 366 days are being reported against an original 454. All of the key performance indicators have been met this year with the exception of the management responses. It is believed that the target would have been achieved without the impact of Covid-19.

Internal Audit are slightly behind on days but are currently undertaking two pieces of work related to COVID-19. 129 recommendations have been made this year, compared to 127 last year. Two reports are left in draft so this number will increase slightly.

DS asked if there will be any follow up on the estates management and expenditure follow up audit. The Internal Audit Manager confirmed that all limited assurances are followed up but not necessarily through a further specific re-audit.

The Head of Internal Audit reported that the Audit and Risk Committee approved the internal audit plan in April 2019 and has tracked, managed and monitored the progress throughout the year. There have been a number of difficulties, particularly from March 2020 due to the pandemic.

All of the recommendations raised have been agreed by the Trust, demonstrating the level of engagement by the Trust. There are three key elements which are taken into account in order to provide a meaningful opinion on the audit system, which will support the annual governance statement. Details of the four limited assurances were included in the report. The Head of Internal Audit noted that there is some ongoing collaborative work between the Chief Nurses to consider how to improve the use of EPR.

The Head of Internal Audit gave an opinion of significant assurance for the year.

OUTCOME: The Committee **NOTED** the Head of internal Audit Opinion.

g) Year End Audit Report – ISA 260

The External Audit Partner KPMG presented the key findings within the ISA260:

- There is one unadjusted audit difference, carried forward from 2018/19. There is one adjusted audit difference relating to 2019/20.
- KPMG have agreed minor presentational changes to the accounts with Finance, mainly related to compliance with the Group Accounting Manual.
- In addition to routine requests, as per last year, KPMG are asking for management representations over the valuation of the Intangible EPR asset.

The External Audit Partner KPMG formally thanked the teams both at KPMG and the Finance Team at CHFT for their work which has meant the audit has gone reasonably smoothly, allowing a clean opinion on the financial statements.

The External Audit Partner KPMG advised that KPMG have concluded that the Trust does have adequate arrangements to secure economy, efficiency and effectiveness in its use of resources, except for the continued underlying deficit position that means it is unable to deliver a break-even position without further support from the Department of Health and Social Care. This is an improvement on past years when adverse opinion was given.

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

RH and the Chair formally thanked the Director of Finance, the Deputy Director of Finance and the Financial Controller and teams for their efforts in ensuring a quality set of accounts were prepared in a timely manner under the current circumstances enabling a clean opinion to be given. Thanks were also offered to the External Audit Partner and her team.

The Chair requested that KPMG arrange for the report to be proof-read for a final time as he had noted a few typographical errors.

OUTCOME: The Committee APPROVED the External Auditor's year-end report and ISA 260.

h) Self-Certification Licence

The Company Secretary advised that each year NHS England / Improvement (NHS E/I) requires all Foundation Trusts to complete a number of self-certifications to provide assurance that the Trust is compliant with the conditions of their NHS provider licence.

A paper was presented to the Audit and Risk Committee on 7 April 2020 describing the compliance with the Code of Governance which informs the self-certification statements. These are to be signed by the Trust Chair and Chief Executive. They are not submitted but are auditable by NHS Improvement.

The Chair asked if the Trust was reaching a point where it would be possible to challenge the licence breach and it was noted that we are getting to a position where we could challenge the licence breach. The Company Secretary and Deputy Finance Director have discussed this and advised that this may be the last one which is written in this way.

RH commented that discussions will take place in the foreseeable future. The Chief Executive added that it is not purely an assessment against the financial accounts but also relates to reconfiguration and the capital monies needed by the Trust for this. Given the uncertainty regarding capital monies nationally the Trust could well remain in breach..

OUTCOME: The Committee APPROVED the self-certification statements.

44/20 ANY OTHER BUSINESS

a) Review of Annual Workplan 2020-21
The Chair pointed out that the Annual Workplan for 2020-21 is available in the Review Room. The workplan has been reviewed and updated to ensure that all postponed items have been included where relevant.

b) AG advised that the CHS Board meeting had been held immediately prior to the Audit and Risk Meeting on 16 June 2020 and authorisation was given to sign off the accounts subject to the conclusion of one outstanding piece of work by KPMG in respect of the COVID-19 risk. The External Audit Partner, KPMG, confirmed that this will go through an independent review and should be signed off internally within the next few days.

c) The Chair formally thanked the Finance Team and the Auditors for the work involved in ensuring the meeting ran smoothly and in particular the Company Secretary for the excellent work on the Annual Report and Governance Statement.

45/20 MATTERS TO CASCADE TO BOARD OF DIRECTORS

Not discussed.

46/20 DATE AND TIME OF THE NEXT MEETING

Wednesday 22 July 2020 commencing at 10am via Microsoft Teams.

QUALITY AND WORKFORCE COMMITTEE

Monday, 4 May 2020 via MS Teams

56/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director / Chair of Quality Committee **(Chair)**
Helen Barker **(HB)**	Chief Operating Officer
Samantha Bryant **(SB)**	Assistant Patient Advice & Complaints Manager
Andrea Dauris **(AD)**	Associate Director of Nursing, Quality and Safety
Suzanne Dunkley **(SD)**	Director of Workforce and Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Adam Matthews **(AM)**	Workforce Reconfiguration Lead
Andrea McCourt **(AMcC)**	Company Secretary
Maxine Travis **(MT)**	Senior Risk Manager
Debbie Winder **(DW)**	Head of Quality from CCG
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

DS gave an introduction to the meeting, and stated that a record of deferred agenda items will be kept and postponed to a later date.

57/20 APOLOGIES

Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Christine Mills **(CM)**	Public-elected Governor

58/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

59/20 MINUTES OF THE LAST MEETING

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

The meeting scheduled for Monday, 6 April 2020 was cancelled due to COVID-19.

60/20 ACTION LOG AND MATTERS ARISING

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

It was stated that there are a number of actions which are now overdue, and in light of current circumstances, these will be carried forward until they can be actioned.

61/20 SERIOUS INCIDENT REPORT

Maxine Travis (Senior Risk Manager) presented a summary of new serious incidents declared and a summary of learning from serious incident reports for the period of January to April 2020 (see appendix C).

Following the serious incident panel on Friday, 1 May 2020, one never event was declared, involving wrong site surgery in a dermatology case. This will be included in the next report. Commissioners and CQC have been made aware.

Appendix 1 of the paper lists the new serious incidents reported to Commissioners and appendix 2 details the completed investigations from January to April 2020.

OUTCOME: The Quality and Workforce Committee received and noted the report.

62/20 COMPLAINTS SERVICE REPORT

Samantha Bryant (Assistant Patient Advice and Complaints Manager) presented an overview of the complaints service during quarter 4 2019/2020, prior to the pause on all complaint investigations as a result of Covid-19, following directive received from NHS England and NHS Improvement (see appendix D).

Key messages:

- 105 formal complaints were received in quarter 4 of 2019/20, and the Patient Advice and Liaison Service (PALS) team dealt with 416 informal concerns.
- The top three complaint subject themes were clinical treatment, communications and patient care (including nutrition and hydration).
- 16 complaints were re-opened due to complainants being dissatisfied with incomplete or factually incorrect responses
- In quarter 4, an anonymous questionnaire was sent to all past and present complaint investigators in divisions to ascertain whether they needed more training or support in compiling the investigation responses. A complaints investigator-specific training module on the Electronic Staff Record (ESR) is being developed, as well as the utilisation of a 'buddy' system for complaint investigators with administrative assistance in compiling the complaint response.
- Prior to the pause on complaint investigations, investigator training needs and support and the completion and closure of actions were the Complaints Team's primary focus. However, since the pause, the team are utilising this time to assist divisions in the writing of their complaints responses in order to free up clinical staff to focus on the pandemic.

  This is also a good opportunity to identify any obstacles or good progress with regards to the potential 'buddy' system. The complaint responses are also being divisionally approved by the Complaints Manager and the Assistant Complaints Manager prior to being signed off by the Company Secretary. Feedback is regularly being provided to the Associate Directors of Nursing so that they are still aware of the complaints that are being managed, and the quality of the responses that are being received for review.

  This plan will ensure that when service resumes the workload of complaints will be manageable and the aim is to reduce all open complaints substantially, which will allow more time to focus on training, support and the completion of actions after this current climate.

Discussion took place on the effort and hard work done to see the positive trend which will hopefully continue. It was asked how soon the e-learning package will be ready, and SB stated that this may take two to three months. The e-learning will run alongside the Trust induction and will also include a patient story and patient experience video, which will make the impact more powerful.

Further discussion took place on whether there was any relaxation on complaints and what the April data for new complaints was showing. SB stated that there has been a reduction of 50% in complaints received, however, the PALS concerns are still incoming.

Following the results from the deep dive presented at a previous meeting, it was asked what risk mitigations are in place as there are a lot of action plan follow-ups which are similar to those of serious investigations. SB stated that actions from complaints are now being reported better and would like assurance that complaints are fully closed, by taking around 15 complaints from 3 years ago, and ensuring that each action has been completed. Work is ongoing with the CQC Compliance Manager and the audit team to see if this can be been done via walk rounds. SB to also liaise with MT as there may be some commonalities in serious incidents and complaints, and MT stated that a deep dive into serious incidents will be presented at a future meeting.

63/20 HIGH LEVEL RISK REGISTER

Maxine Travis (Senior Risk Manager) presented appendix E providing a summary of the high level risk register and the COVID-19 risks.

The high level risk register is similar to previous months, with the exception of a new risk on the workforce model in the emergency department and compliance with children's guidelines; and the increase of a maxillofacial follow-up appointments risk. The COVID-19 risk register has approximately 80 risks included and the risks are at a point in time, with no significant changes to the risk ratings.

Discussion took place on the process for getting new divisional risks onto the high level risk register, due to recent divisional Patient Safety and Quality Board meetings not taking place. MT stated that no non-COVID risks have been proposed for acceptance, however, a Risk and Compliance Group meeting is due to take place at the end of the month. Any COVID-related risks are proposed by the divisions and taken through the Incident Management Team where all high level and amber risks are reviewed on a weekly basis.

OUTCOME: The Quality and Workforce Committee received and noted the report.

64/20 HEALTH AND WELLBEING OFFER

Suzanne Dunkley (Director of Workforce and Organisational Development) presented the offers that CHFT have put in place for health and wellbeing and how to respond to COVID-19, including a health and wellbeing strategy. This is broken down into three phases: prepare, active and recover, with CHFT currently between active and recover.

There are multiple guides available for colleagues including a guide to working from home, how to reduce COVID-19 anxiety, mindfulness, one-to-one emotional and psychological support, counselling support, bereavement support and external support. Podcasts and sessions streamlined to colleagues are also available and the development of activities to enhance a sense of community. Letters have been written letters to colleagues who are shielding, school children and head teachers of schools; video recordings thanking the fire, ambulance and police services, supermarkets, bus drivers, etc which will go live on Wednesday. The next phase will be in collaboration with trade unions and colleagues across the trust.

Discussion ensued on the great work which has been done with psychologists and freedom to speak up colleagues, guidance and top tips for leaders and managers to reintegrate relationships and help staff transition back into the world of work, as some may feel reticent to do so. 24/7 specialist counselling and psychological support will continue, and further details of all the offers available can easily be accessed by all via the intranet.

65-67 /20 WORKFORCE (INCLUDING SICKNESS, RECRUITMENT AND STAFFING LEVELS)

Adam Matthews (Workforce Reconfiguration Lead) presented highlights from the Workforce report (appendix G) on recruitment as at 31 March 2020 and sickness absence as at 13 April 2020.

The overall workforce domain score was 84.5%, with return to work interviews and Essential Safety Training for Manual Handling and Safeguarding RAG rated as amber. 352 colleagues were recruited, with 262 at the conditional offer stage.

656 of the workforce were absent in April 2020 due to sickness, with 334 COVID-19 related and 322 non-COVID-19 related. Out of 443 staff tested, 321 had a negative result, 115 were positive and 7 were being awaited.

On this occasion, the Workforce report was produced 'light', therefore no data on staffing levels was available.

68/20 COVID RELATED ISSUES

Helen Barker (Chief Operating Officer) provided an update on COVID-related issues.

Over 2140 patients have been tested for COVID-19, of which 402 were positive. There have sadly been 129 deaths up to this point, and CHFT still has 39 inpatients who have tested positive, of which 7 are in critical care, with a further 30 patients who have tested twice for COVID-19 and still have symptoms, therefore being treated as positive. More than 260 patients have been successfully discharged, 10 of whom were in critical care.

Personal Protective Equipment (PPE) daily meetings are taking place with a clear focus on safety, not cost. A daily equipment meeting also takes place, as well as a daily Incident Management Team meeting where new incidents and updates on risks take place. A detailed review of the risk register took place last Friday, enabling to reduce some of the staffing risks. Key risks on the register include two outbreaks; one on ward 20 where a patient developed COVID-19 and became positive. It was not known if the patient was admitted with it or contracted it on the ward; and an outbreak of line infections on critical care at CRH.

5000 patients who should have had a follow-up appointment are now being clinically validated, and cancer services have maintained one theatre list a day, treating level 1 and 2 patients. Plans are still being worked through for level 3 patients.

Looking forward, the challenges are the new requirements to test asymptomatic patients on admission and zoning plans. This will be a fundamentally different way of managing patients, which will probably remain in place through the winter; therefore plans are being worked through in detail.

69/20 ANY OTHER BUSINESS

- Integrated Performance Report

  This item was not taken and removed from the agenda.

- Quality Account

  Andrea McCourt (Company Secretary) stated that the requirement to include the quality account in the annual report has been removed for this year; however, consideration is needed on what is done with the document, following a refresh. It was asked if there is a standardised approach for the backlog of deferred items and AMcC stated that a stock take is being taken of meetings which are taking place and those which are not. A consistent approach will need to be agreed on a volume of deferred items and this will need to be captured centrally.

- Risk assessments for Black, Asian and Minority Ethnic (BAME) colleagues

  There has been a lot of discussion nationally around risk assessments of certain community and staff groups, with specific reference to BAME colleagues. Basic guidance has been received from NHS England and Improvement, and the Chief Executive is keen to get the views of BAME network colleagues for their perspective on what our Trust and its partners' approach should be.

- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)

  There is some inconsistency in the advice that Trusts are receiving regarding the reporting of COVID-19 infections as part of the RIDDOR reporting process. CHFT will be seeking advice from them separately, and in the meantime, will not be reporting COVID-19 infections to RIDDOR.

70/20 MATTERS TO REPORT TO THE BOARD OF DIRECTORS

The Chair and Vice-Chair will provide feedback to the Non-Executive Directors on the meeting and how to manage the list of agenda items which have been deferred.

71/20 EVALUATION OF MEETING

The meeting finished on time and was the first meeting on MS Teams.

72/20 QUALITY COMMITTEE WORKPLAN

The Quality Committee work plan for 2020 was available at appendix H.

The Chair, alongside the Assistant Director for Quality and Safety and the Governance Administrator, will review the management of the work plan going forward.

NEXT MEETING

Monday, 1 June 2020 at 3:00 – 4:30 pm via MS Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 4 MAY 2020

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
ACTIONS DUE AT THE NEXT MEETING				
2.3.20 (51/20)	**FRIENDS AND FAMILY TEST CHANGES**	Lindsay Rudge	**Update 2.3.20**: Changes to the Friends and Family Test are due to come into effect from 1 April 2020. **Action 2.3.20**: Presentation on changes to be provided.	**DUE 1 JUNE 2020**
ACTIONS STILL OPEN				
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	**ACTION REMAINS OPEN** **ACTION REMAINS OPEN**
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	**ACTION REMAINS OPEN**
2.3.20 (47/20)	**SURGERY AND ANAESTHETICS Q3 PSQB REPORT**	Surgical Division	**Update 2.3.20:** There was no representation from the division. **Action 2.3.20**: Report to be deferred to next month	**ACTION REMAINS OPEN**
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.	**ACTION REMAINS OPEN**
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	**ACTION REMAINS OPEN**
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.	**ACTION REMAINS OPEN**
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	**ACTION REMAINS OPEN**

QUALITY AND WORKFORCE COMMITTEE

Monday, 1 June 2020 via MS Teams

73/20 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director / Chair of Quality Committee **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Mark Bushby **(MB)**	Workforce Reconfiguration Lead
Andrea Dauris **(AD)**	Associate Director of Nursing, Quality and Safety
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Carole Gregson **(CG)**	Associate Director of Digital Health/CNIO
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Philip Lewer **(PL)**	Chairman **(Observing)**
Andrea McCourt **(AMcC)**	Company Secretary
Maggie Metcalfe **(MM)**	Associate Director of Nursing – Medical Division
Joanne Middleton **(JMidd)**	Associate Director of Nursing – Surgical Division
Christine Mills **(CM)**	Public-elected Governor
Elizabeth Morley **(EM)**	Associate Director of Nursing – Community Division
Dr Julie O'Riordan **(JOR)**	Divisional Director – FSS Division
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Maxine Travis **(MT)**	Senior Risk Manager
Michelle Augustine **(MAug)**	Governance Administrator **(Minutes)**

74/20 APOLOGIES

Dr David Birkenhead **(DB)**	Medical Director
Suzanne Dunkley **(SD)**	Director of Workforce and Organisational Development

75/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

76/20 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Monday, 4 May 2020 were approved as a correct record.

The action log, which can be found at the end of the minutes, has a number of actions which remain open. Further discussions to take place outside of the Committee regarding where actions will sit on the recovery plan. This will be updated at the next Quality Committee with a realistic view on where outstanding actions will fall over the next few months.

Matters Arising

Andrea McCourt (Company Secretary) reported that since the last meeting, there has been confirmation that our Quality Accounts now need to be formally submitted by mid-December 2020. The stakeholder exercise still needs to be undertaken for comments; however, the external auditors do not need to receive the document for comment. The current document will need a review on the quality priorities going forward, and the approval of the Quality Account has been delegated from the Board of Directors to the Quality Committee. This will need progressing later in the year.

77/20 COVID-RELATED DEATHS

Dr Cornelle Parker (Deputy Medical Director) presented a paper at appendix B, providing assurance of the escalation decisions to critical care for COVID-positive patients who died.

The report is based on structured judgement reviews (SJRs) of 10 randomly selected mortalities from designated wards that occurred between 23 March and 17 April 2020.

The findings of the SJRs were outlined in the report as well as good practice identified. The review provided limited assurance regarding escalation to critical care. There were no concerns raised regarding the appropriateness of decisions to escalate or not escalate however, only two of the cases reviewed relate to cases where the patient was escalated. A further review of cases is required in order to understand if escalations that do occur are appropriate.

The next steps are for the learning from death team to conduct further SJRs on a larger group of patients, specifically those escalated to critical care, to review decision making. Consideration needs to be given to ensure the selected cases are reflective of the demographics for overall cases. A further paper regarding Covid mortality is to be submitted to Board of Directors in July 2020, and this paper will additionally focus on analysis of the nationally identified Covid risk factors.

It was asked whether the patient that was classified as a serious incident, seemed to have an issue with access to continuous positive airway pressure (CPAP). It was asked if this was a one-off. It was stated that there wasn't ever a decision based on the lack of CPAP machines. The patient location was an issue, therefore access to a device was not available at the location, but not due to lack of machines.

It was stated that the report is showing good practice, however, there was a noted shortage of reviewers. Going forward, it was asked if the Trust will be in a better position to have reviewers who are available. CP reported that at the time, three of the reviewers, who are anaesthetists, were pulled into clinical roles.

It was asked how well the good practice is being disseminated, and CP reported that before COVID, this was attempted; therefore the form is structured to pull out the positive information directly from the review to named individuals and also back to divisions.

OUTCOME: The Quality and Workforce Committee received and noted the report.

78/20 COVID RISK REGISTER

Maxine Travis (Senior Risk Manager) presented appendix C1 providing an overview of the COVID-19 risks.

There are a total of 89 COVID-19 risks, comprising of:

- Eight red (scoring 15+)
- 57 amber (scoring between 8 and 12)
- 24 green (scoring between 1 and 6)

A breakdown of the risks by division was also provided, as well as descriptions of the eight red risks. A copy of the full COVID-19 risk register was also available at appendix C2

MT stated that the COVID risk register is discussed and challenged at the Incident Management Team meeting on a weekly basis, and is very much a live document, which does not require as much reminding for updates as the high level risk register. It was stated that there could be some learning for updating risk registers.

OUTCOME: The Quality and Workforce Committee received and noted the report.

79/20 DIGITAL COMMUNICATIONS

Carole Gregson (Associate Director of Digital Health and Chief Nursing Informatics Officer) was in attendance to inform the Committee of the Trust's approach to visiting and communication during the COVID-19 pandemic in relation to technology and end of life care.

CHFT's approach to visiting during COVID-19 was based on NHS England guidelines and tailored by the Trust to incorporate digital technology to enhance the patient and family experience. Alongside this, CHFT has explored other digital technology to support care of the most vulnerable patients at the end of their life. NHS England guideline has suspended visiting until further notice; however, exceptional circumstances are permitted. The Trust was acutely aware of the impact a ban on visiting to the hospital would have on patients and their families, therefore were challenged in how to provide support through digital solutions regarding visiting and enhanced care through various means. This included virtual in-hospital visiting, correspondence from loved ones, ward specific solutions and virtual ward rounds, all of which were detailed in the report.

Huge thanks were conveyed to CG for her leadership and the work that her team has done on this excellent initiative. It was also stated that this has been submitted to the Nursing Times awards.

OUTCOME: The Quality and Workforce Committee received and noted the report.

80/20 FRIENDS AND FAMILY TEST CHANGES

Lindsay Rudge (Deputy Director of Nursing) presented appendix E, which described the national changes made to the friends and family test (FFT) questions, the suspension of reporting to NHS England and Improvement, and the reduced activity in response to NHS England guidance.

The Trust was prepared for changes to the friends and family test which were introduced last year and were due to come into effect on 1 April 2020.

Notification from NHS England and Improvement aimed to reduce the burden and release capacity to manage the COVID-19 pandemic; suspend the submission of FFT data to NHS England and Improvement from all settings until further notice; to stop using methods of feedback collection that may pose an increased risk of infection to either staff or patients (e.g. feedback cards or iPads/tablets); continue listening to patients and enabling them to raise concerns about the services they are using.

NHS England and Improvement will advise when to restart submitting FFT data later in the year and will allow for a period to make the necessary preparations before implementation.

The Trust's current position is continued use of SMS messaging in outpatients and the emergency department, and a proposal from the Patient Experience and Caring Group is that some inpatient wards pilot the use of the website by promoting its use via business cards, which will commence in June 2020. Work is ongoing with the Infection Prevention and Control team to provide feedback collection using cards / tablets safely and there will be a standard operating procedure in place to test this.

The Trust will look to restart testing in the new format and will keep the Committee updated.

OUTCOME: The Quality and Workforce Committee received and noted the report.

81/20 MEDICAL DIVISION PSQB SUMMARY REPORT

Maggie Metcalfe (Associate Director of Nursing) was in attendance to present the division's patient safety and quality report, highlighting how keeping the base safe has been maintained and how changes have been made in the division in response to COVID-19.

Keeping the base safe has been maintained by:

- Patient Safety and Quality Boards (PSQB) and Directorate Boards being reinstated with modified agendas, to reflect the information available, for example Safety Thermometer and FFT data is not being collected at the moment
- The division maintaining complaints review panels, orange panels and continuing to review / discuss / manage the risk register.
- Divisional Management Board meetings commencing and taking place during alternating months with the PSQB for continuity through the pandemic.
- The divisional Infection Prevention and Control (IPC) meeting being reinstated from June 2020, and as corporate-led meetings restart, the division will ensure regular attendance recommences.
- Orange panel meetings continuing to take place via Microsoft Teams as well as directorate incident closure meetings

Changes to the service included:

- Executive-approved bed plans to reflect the different stages of escalation.
- Patient consultations via telephone or video conferencing, only face to face if required / appropriate.
- Both Emergency Departments (ED) managing to open two separate ED's in a short time frame with minimal disruption to patient care and safety. This was always complying with infection control policies and working closely with the infection control team, estates and domestic services.
- The helpline for oncology / haematology having to expand during COVID-19 to cover 24/7. This worked extremely well and is something the division wish to look at permanently.
- Chemotherapy units merging to one site and working extremely hard and extremely well together to support each other and the patients. During this time, they received an official compliment from a patient which was very positive and a credit to them as a team.

Colleagues from the division were deployed into other areas and will be trying to keep their skills up-to-date in order to keep a skill force for the future. The division also had end of life care wards on both sites, and will be looking to have designated end of life care beds on each site going forward.

The incident, falls, pressure ulcers and complaints position for the division were also included in the report.

The Chair conveyed thanks to all colleagues in the division.

OUTCOME: The Quality and Workforce Committee received and noted the report.

82/20 SURGICAL DIVISION PSQB SUMMARY REPORT

Joanne Middleton (Associate Director of Nursing) was in attendance to present the division's patient safety and quality report, highlighting the division's response to COVID-19.

In response to the COVID-19 outbreak, the division rapidly adapted in preparation for, and in expectation of an influx of acutely ill patients who would require Critical Care intervention. A staffing plan was developed that deployed over 200 staff members from across the organisation into Critical care with a plan in place that would support up to 48 level-3 beds. This was supported by a training and education plan delivered by the clinical education team and critical care nursing team.

In early March 2020, the decision was made both nationally and locally to step down the majority of elective surgery. The division continued to perform a small number of time critical and urgent, Cancer and Orthopaedic trauma cases as well as maternity provision. Interim

workforce models were implemented to ensure the right skill mix was in place to deliver a flexible and responsive service.

The division rapidly adapted its areas to be able to accommodate the expected volume of COVID-19 patients. Wards 10 and 11 merged onto Ward 11, and Ward 22 and Ward 3 merged onto Ward 22. This enabled further redeployment of teams into escalation areas. A training plan was delivered and continues to be delivered to support training needs in these areas. Competency packages have been developed which will support further transformation post-COVID. An example of this is enhanced recovery in Trauma and Orthopaedics for healthcare assistants based on the successful principles in place across elective orthopaedics.

Most outpatient appointments were reviewed and converted to virtual appointments where clinically relevant and appropriate.

Many staff had to shield themselves and isolate at home due to pre-existing health conditions. Some have been off work sick themselves and others, where feasible, have worked from home. Across the Trust, our teams and our infrastructure have had to rapidly adapt to this new and fast changing environment. The division has embraced Microsoft Teams to keep in touch with one another whether at home or on site, and so that the necessary meetings utilised to conduct business could continue.

PSQB meetings were held as normal in January and February 2020, with the March 2020 meeting being stepped down due to the COVID-19 outbreak. The Quality Governance Lead post was vacant from mid-February. During this time the Incident Management Team have supported the continuation of the orange panel within the division. The Quality Governance Lead post has now been appointed to.

The report continued to show the division's position with incidents received in quarter 4, the incident themes, complaints and patient experience. With regard to complaints actions going forward, the division plan to play close attention to actions set by directorates to ensure they are SMART - Specific, Measurable, Achievable, Realistic and Time Specific, and for directorate minutes to evidence discussion and any agreement of how learning will be shared. The operating services and critical care directorates tested out this new process in May which covered actions for January 2020 to March 2020. This approach will be rolled out to other Directorates in June.

Discussion took place on staffing levels which are now reducing and being monitored. The Chair stated that it would be useful to get an update on the approach used to manage outstanding actions and learning from complaints. JM agreed for this to be submitted as part of the next report.

The Chair conveyed thanks to staff in the division.

OUTCOME: The Quality and Workforce Committee received and noted the report.

83/20 COMMUNITY HEALTHCARE DIVISION PSQB SUMMARY REPORT

Elizabeth Morley (Associate Director of Nursing) was in attendance to present the division's patient safety and quality report, highlighting how keeping the base safe has been maintained and how changes have been made in the division in response to COVID-19.

The division initiated a daily Bronze call where daily messages and implications from organisational groups, such as tactical and Personal Protective Equipment (PPE) were shared. Decisions regarding risks and concerns were discussed, as well as agreement of points for escalation.

The PSQB meeting was cancelled in March, but went ahead in April. This was however brought forward a week in light of the March meeting's cancellation.

Orange panels have been taking place but temporarily changed to fortnightly in late March through to the end of April.

There were some changes to service; however, not all could be stepped down due to patients still needing to be visited in their own homes. Some changes included:

- The District Nursing service implementing a nursing prioritisation plan to ensure patient's safety is maintained whilst managing the impact of COVID-19 on the service. All community nursing teams were called upon to increase their support into Calderdale care homes and working hours were adapted. The Quest for quality / Frailty / Outpatient Parenteral Antimicrobial Therapy (OPAT) pathways were developed to reduce the needs for admissions to hospitals
- All specialist nursing clinics were put on hold, with face-to-face contact stopped, and teams contacting patients via telephone and providing advice. There is also the possibility of completing rehabilitation classes with the use of telehealth.
- All routine face-to-face contact with community therapies were stood down. Consultations and advice were provided over the phone.
- Inpatient Therapies staff continued to support inpatient areas and some were redeployed into new areas

An enhanced support team for care homes in Calderdale was quickly established by the division, and part of the role of the team was to facilitate treatment with antibiotics and intravenous fluids for residents who became unwell and required this intervention. This treatment would usually only be offered in the hospital setting, however, the ability to offer this treatment in the community and more specifically in the patient's home, resulted in residents of care homes staying within a familiar environment, with people that they knew and stopped the need for a transfer to hospital. The division are now looking to sustain this service and offer it more widely.

The report also highlighted the division's position with incidents and complaints.

Discussion ensued on whether the new service has been quantified in numbers by seeing how many patients were able to avoid coming into hospital. EM stated that the data is still poor and still COVID-related, but will be monitored over a period of time to see the demand.

The Chair conveyed thanks to the flexibility of staff in the division.

OUTCOME: The Quality and Workforce Committee received and noted the report.

84/20 FAMILIES AND SPECIALIST SERVICES (FSS) DIVISION PSQB SUMMARY REPORT

Dr Julie O'Riordan (Divisional Director) was in attendance to present the division's patient safety and quality report, highlighting how keeping the base safe has been maintained and how changes have been made in the division in response to COVID-19.

Due to the COVID pandemic, the division suspended business as usual (BAU) in order to support direct patient care. To keep directorate colleagues updated during this rapidly changing time, the FSS Senior Management Team (SMT) instigated a daily COVID hub, via Microsoft Teams to disseminate information. Directorate teams were also allocated a weekly 30-minute time slot immediately after the hub meeting to meet with the SMT in lieu of the Directorate Performance meetings. These short weekly meetings provided directorates with protected time to meet with the SMT to either escalate non-COVID concerns or provide assurance that pre-COVID BAU was continuing (for example Essential Safety Training).

Changes to the service included:

- Maternity services, due to their nature, continuing to see steady numbers of women through both hospital and community antenatal and postnatal clinics. These have been operated using a combination of face-to-face and virtual / telephone appointments.

- Colleagues in Pathology being an integral part to the instigation and expansion of COVID testing, whilst maintaining essential pathology services. This has meant that colleagues worked throughout all areas of Pathology to maintain services. It was stated that outside of Leeds, CHFT were the only trust carrying out its own testing, therefore having a quick turnaround time..
- Pharmacy's workload increasing to support the provision of aseptics, and batch-made intravenous drugs to support patients on ICU. By the nature of COVID-19, daily pharmacist visits to ward areas were discontinued and replaced by increased pharmacists in the department offering telephone advice to staff.

- Radiology embedding a Radiographer within the COVID ED to support rapid access to chest x-rays for patients. Radiologists worked closely with colleagues in other divisions to formulate pathways of care that avoided the unnecessary ordering of radiological examinations for patients, ensuring that early access was available for those patients in greatest need of any examination.

- All routine outpatient clinics being suspended due to COVID-19 and the majority of nursing staff redeployed to support patient care in other areas of the hospital, for example ED, ICU or the respiratory wards.

All staff in each department have conducted themselves professionally during this period of rapid service change, new PPE requirements, including the use of face masks for direct patient care, social distancing, and also redeployment away from their base areas, showing great team work and a commitment to one Culture of Care.

PSQB meetings were stepped down and now reinstated. Weekly orange panels have continued to take place via Microsoft Teams. Timelines for newly reported incidents are presented and dealt with at divisional level or escalated to serious incident (SI) panel. Draft reports have also been presented by the investigators and either signed off or brought back following additions/amendments.

The report also highlighted the division's position with incidents and complaints. In relation to patient experience, the introduction of Dect phones to senior clinical decision makers have allowed primary care colleagues to discuss individual patient concerns, and prevent unnecessary admissions to both paediatric and gynaecology wards.

Discussion took place on how pathology staff are coping with the increased work. It was stated that due to a reduction in other testing due to the reduction in inpatients and primary care tests, staff have been moved into the laboratory with additional training and have worked well on that. JE also stated that pathology staff have been excellent with testing to establish if staff have been COVID-positive or negative, and now working with establishing an approach for antibody testing, which will be on offer from Wednesday, at the latest.

The Chair conveyed thanks to the staff in the division.

OUTCOME: The Quality and Workforce Committee received and noted the report.

85/20 RECRUITMENT, SICKNESS AND STAFFING LEVELS

Mark Bushby (Workforce Reconfiguration Lead) presented appendix J, highlighting the recruitment, sickness and staffing levels from the workforce integrated performance report, showing data for April 2020.

Return to work interviews recorded is red, with manual handling essential safety training at amber. MM stated that manual handling training had to be modified and needed to reduce the numbers of people doing the training due to social distancing. The overall domain score is 93.5%, which excludes appraisal data. Staff in post have increased by 119, with the bulk

being student nurses. There were 125 new starters for the month, with budgets reset for the new financial year. Staff turnover has reduced.

Sickness has increased, with anxiety, stress and depression being the top reasons, overall essential safety training is at 93.61%, and workforce absence in May 2020 was 537, with 281 related to COVID-19 and 256 other sickness. 726 staff have been tested, with 596 negative and 156 positive and 14 awaiting results.

KH stated that at the beginning of this, there was a drive to bring those who had retired back into the workforce, and asked if they were part of the data. It was stated that not many people fit into the criteria to return to work, and there were two streams – one was the national bring back staff scheme where 60,000 people were invited (CHFT had some members across this group), as well as CHFT's own work stream of staff who had retired in the last two years (see data below)

	Bring Back Staff (national campaign / scheme)	**CHFT returners**
Allied Health Professionals	2	4
Additional Clinical Services	1	7
Nursing and Midwifery	15	11
Healthcare Scientists	0	1
Total	**18**	**23**

There was a lower amount of colleagues who volunteered and most of the additional workforce was through accelerated recruitment, student nurses and via the bank system.

JE reported on an exceptional job and credit to colleagues to keep essential safety training at its position. This has been linked to pay progression, and the appraisal season was agreed last week at IMT to be from July to October 2020.

The Chair asked if the Trust has benefitted from an increase in applicants due to the 'NHS feel-good'. JE stated that there were a lot of vacancies in system anyway, but there is a view that the bring back staff scheme should fill vacancy positions across the NHS. This will be able to be tested in the months to come. MM also reported that some staff who were deployed to outside their normal working practice, have said that they have enjoyed working in that area, and may be willing to work in other areas.

JE reported that absence figures are reducing, and as of Thursday, 552 were absent from work, with 283 COVID-related, 218 shielding and 158 in the high-risk shielded category. 50 fall into high risk and 10 being reassessed. Work is ongoing in divisions to ensure the right categorisation and determining whether colleagues can return to work.

86/20 HEALTH AND WELLBEING OFFER

Jason Eddleston (Deputy Director of Workforce and Organisational Development) presented an update on the CHFT health and wellbeing offer at appendix K. The focus of the next phase – reset and renew was included in the report.

The expectations, actions and resources for the prepare, active, recover and reset phases were shared and reported that the well-being offer was well-accessed and well received and supportive of evidence in the organisation with one culture of care being embedded.

The focus of this report was the reset and renew phases of health and wellbeing support, which includes:

- One culture of care to be the key enabler / driver / purpose
- More targeted support to specific groups (including teams in need, or by location / proximity to high concentration of COVID+ deaths or care / colleagues shielding– emphasis will be on proactive support

- Listening events and Schwartz Rounds high priority
- 24/7 counselling services to continue and to procure external services that cannot be delivered in-house
- Managers guides continue to be produced – compassionate communication / reorienting colleagues back into their workplace / supporting roles to continue working from home / BBTU daily briefs and debriefs
- Wellbeing champions assigned to each service / ward / department to champion breaks, hydration, access to freedom to speak up, rotas, physical and mental wellbeing activities.

Discussion took place stating that this goes beyond COVID-19 and is a good springboard for moving forward, and staff will recognise the value of it when the staff survey is due.

Thanks were conveyed to colleagues in the Workforce and Organisational Development department for the phenomenal job in providing this resource, supporting staff and the level of strategic oversight done. The business intelligence team have also done great work with health informatics to allow the data to be easily read.

87/20 STAFF TESTING AND INITIAL PROTECTED CHARACTERISTICS ANALYSIS DATA

Mark Bushby (Workforce Reconfiguration Lead) presented appendix L, highlighting the breakdown of reported data from staff testing.

558 tests were carried out for staff displaying symptoms, with 114 providing a positive result. The medical division reported a significantly higher number of positive results compared to other divisions, and 35 of the positive cases within the medical division were found in the acute medical directorate. The report also breaks the data into gender, staff group and BAME individuals.

It was asked if this analysis is planned for the future, and it was stated that work is taking place with the rostering team to ensure that staff are in the correct locations in order to have accurate data on where staff were deployed.

CP reported that the high figure of positive cases in the acute medical directorate is not an area that is prone to carrying out Aerosol Generated Procedures (AGPs), therefore will follow this up with the Medical Director.

88/20 CLINICAL ETHICS PANEL TERMS OF REFERENCE

A copy of the Clinical ethics panel terms of reference were circulated at appendix M for information.

89/20 ANY OTHER BUSINESS

There was no other business.

90/20 MATTERS TO REPORT TO THE BOARD OF DIRECTORS

The Chair to update the Board of Directors at the next meeting on Thursday, 2 July 2020.

91/20 EVALUATION OF MEETING

A good meeting with representation from divisions.

92/20 QUALITY COMMITTEE WORKPLAN

The Quality Committee work plan for 2020 was available at appendix N.

The work plan lists outstanding items that need to return to the Quality Committee.
The due date for the quality account to be revised.

NEXT MEETING

Monday, 29 June 2020 at 3:00 – 4:30 pm via MS Teams

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
UPCOMING ACTIONS				
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.**	**From to be circulated after the meeting on Monday, 29 June 2020, with responses needed by Monday, 8 July 2020**
ACTIONS DUE LATER IN THE YEAR				
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 STILL OPEN				
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.	**ACTION REMAINS OPEN**
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**	**ACTION REMAINS OPEN**
CLOSED ACTIONS				
2.3.20 (51/20)	**FRIENDS AND FAMILY TEST CHANGES**	Lindsay Rudge	**Update 2.3.20**: Changes to the Friends and Family Test are due to come into effect from 1 April 2020. **Action 2.3.20**: Presentation on changes to be provided. **Update 1.6.20: This has now been presented – see item 80/20**	**CLOSED 1 JUNE 2020**
2.3.20 (47/20)	**SURGERY AND ANAESTHETICS Q3 PSQB REPORT**	Surgical Division	**Update 2.3.20:** There was no representation from the division. **Action 2.3.20**: Report to be deferred to next month **Update 1.6.20: The Q4 report has now been presented – see item 82/20**	**CLOSED 1 JUNE 2020**
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**

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Wednesday 6 May 2020 - 3.00 – 4.00 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
Jacqueline Ryden (JR)	Minutes

09/20 APOLOGIES FOR ABSENCE

There were no apologies for absence.

10/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 15 April 2020 were **APPROVED**.

Matters Arising:
AN asked if the governance of the inner core and outer core working arrangements was providing the level of assurance originally envisaged and commented that he would raise this at the Public Board meeting scheduled for 7 May 2020. AB advised that Knowledge Portal Plus had been set up specifically to report on COVID metrics and had real time tracking of COVID positive cases and deaths, with trends presented through graphics. AB added that NEDs could request access to the portal through the THIS Business Intelligence team. AN agreed to discuss this with Julian Bates in the first instance.

Following a request at the last meeting held on 15 April 2020, two presentations on the COVID-19 risk register and the Trust's response to COVID-19 were available in the Convene Review Room.

COVID-19 Risk Register
AM gave an update on the risk register for COVID-19. Key points to note were:

- The score for staffing risks across the board had reduced due in part to the deployment of staff and the easing of restriction on annual leave
- Two new risks had been added relating to the deterioration in patient condition waiting for Outpatient/Inpatient diagnostics and a risk relating to staff becoming infected with the virus
- The score for the risk relating to non-invasive ventilation equipment had been reduced from 20 to 15

Changes Implemented at CHFT in Response to the Pandemic
AB explained that the information provided in the slides would be shared with stakeholders, including staff, patients, health and social care and political colleagues to present the high-level information around strategic details and the changes and reasoning for the changes made. This was still in draft stage and had not yet been circulated. The information would be provided to partners for review before public circulation.

A discussion took place regarding the governance and approach to making decisions regarding the restart / reset of services. AB advised that during May feedback would be sought from partners, colleagues and patients for their views on positive or negative transformations that had taken place and how they saw the future. This will inform both short to medium and longer-term planning. Consideration would be given to the risk/benefit ratio before decisions were implemented. No specific decision had yet been made regarding the route for governance, and AN suggested that WEB to Board would be a possible route.

11/20 TEMPORARY RELOCATION OF THE MACMILLAN UNIT CHEMOTHERAPY SERVICE

AB gave an overview of the decision made by the Outer Core on 16 April 2020 around the temporary relocation of the Macmillan Unit at CRH to HRI. This decision had been made to pre-emptively protect staffing capacity in order to ensure that critical services could continue to be provided and to minimise risk of disturbance to patients. It was noted that relocation had already been enacted when the decision was presented to the Outer Core. The Outer Core supported the decision but asked for an update to provide information on staffing levels and how they had been impacted for consideration by the Outer Core Group on 14 May 2020.

DS noted that there appeared to be a theme emerging regarding communication and engagement with patients and asked if there was a communication plan in place for the future regarding service changes. AB explained that a huge number of telephone calls were made to patients and contact points provided for any concerns. Feedback had been given to the Incident Management Team to reflect on the learning from this.

The Committee **SUPPORTED** the decision made by the Outer Core for the temporary location of the MacMillian Unit Chemotherapy Service.

12/20 TEMPORARY CONSOLIDATION OF AMBULATORY CARE SERVICE

AB gave an overview of the decision made by the Outer Core on 16 April 2020 to consolidate the Ambulatory Care service on the Huddersfield site. A number of potential benefits were identified including the release of 15 beds at CRH to increase capacity, the release of staff for redeployment and the reduction of risk of COVID-19 transmission to outpatients by providing a discrete entry to the unit. Again, it was noted that this recommendation had already been enacted by the Incident Management Team at the time of presenting to the Outer Core Group.

This was a temporary change and it was intended to change back and return AAU to CRH as soon as practicable to do so. The Outer Core Group requested an update for the meeting on 14 May 2020 with a review of whether the additional capacity was still required.

AN queried the expediency of the decisions from a governance perspective. AB recognised that it was not how the process was intended to work but a decision had been made to work at pace during the emergent period running up to the crisis. There has been reflection and learning from this.

The Committee **SUPPORTED** the decision made by the Outer Core for the temporary consolidation of the Ambulatory Care Service.

13/20 TEMPORARY SUSPENSION OF HUDDERSFIELD BIRTH CENTRE

AB gave an overview of the decision made by the Outer Core on 16 April 2020 to suspend services at the Huddersfield Birth Centre with provision of services consolidated at the Calderdale Birth Centre.

The proposal to divert all women in labour to Calderdale Birth Centre and amalgamate birth centre staffing teams was made as a contingency that might be implemented should staffing levels fall due to staff absence from COVID-19. Guidance from the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists was considered. The Outer Core group supported the decision but requested a review of staffing which would be considered at the meeting on 14 May. It was noted that this decision had not yet been enacted.

Following a query from DS, AB confirmed that home births continued to be offered but with a different set of parameters regarding potential risks considered.

AN asked what would the contingency be if demand exceeded capacity, and AB explained there was some predictability in the short term in this area and that the volume at the Huddersfield Birth Centre was quite low and was staffed according to demand. AN suggested that a reference to the demand would be helpful in the decision-making process.

The Committee **SUPPORTED** the decision made by the Outer Core for the potential temporary suspension of the Huddersfield Birth Centre.

14/20 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, considering the background, evidence reviewed when making each decision and discussion points. This register would be updated following Outer Core meetings.

AB advised that two new decisions were to be considered at the meeting on 14 May and would be added to the register:

- Paediatric access pathways into the emergency departments, inpatient paediatric services and to paediatric surgical services
- Increased role of trauma and orthopaedic team to support minor injuries in A&E

15/20 REVIEW OF THE MEETING

In response to the Chair's question on the effectiveness of the meeting, all members and AB confirmed the meeting had worked well in enabling Outer Core decisions to be reviewed and an opportunity for additional/follow-up information to be requested.

16/20 DATE AND TIME OF NEXT MEETING

The next meeting would be held on Tuesday 26 May 2020 at 10.00 am.

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Tuesday 26 May 2020 - 10.00 – 11.00 am
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

17/20 APOLOGIES FOR ABSENCE

There were no apologies for absence.

18/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 6 May 2020 were **APPROVED**.

Matters Arising:

Knowledge Portal Access – AN had contacted Julian Bates in this regard. It was noted that there could be an issue around personal information which would be available on access. AN also suggested there may be an issue of accessing on personal devices rather than Trust devices.

Changes Implemented at CHFT in Response to the Pandemic – it was noted that the response to the circulation of this information had been positive.

19/20 CONSOLIDATION OF CHILDREN'S ACUTE SERVICES

AB gave an overview of the decision made by the Outer Core Group on 7 May 2020 regarding the proposal to consolidate the Children's Acute Services on the Calderdale site in the event of a shortage of paediatric middle grade medical capacity. The phased escalation that had been proposed by the Inner Core Group was noted. The Outer Core had raised a number of concerns, particularly safeguarding issues, and was mindful of the CQC recommendation at the last inspection regarding our configuration of children's services across the two sites. The Outer Core Group had therefore not supported this proposal and made a number of requests back to the Inner Core Group, including sharing the proposal with the CQC for their advice and exploring the possibility of diversion of paediatric surgery to other centres. The proposal was therefore not approved or currently enacted. A further update to explore options was awaited. AB would follow up with

the Inner Core Group to identify a timeline for the provision of further information. DS asked if information about average admission rates could be provided to understand the potential impact of diverting paediatric surgery to other centres. AB would request in the update.

The Committee **SUPPORTED** the decision made by the Outer Core Group.

20/20 ED MINOR INJURY SERVICE

AB gave an overview of the decision made by the Outer Core Group on 7 May 2020 regarding the proposal to manage minor injuries through the ED departments at both CRH and HRI. The proposal was to have a direct route to Huddersfield to see a member of the Orthopaedic team, where the patient was likely to have a definitive treatment. There was also a suggestion that patients attending CRH and not wanting to travel to HRI would continue with the original pathway at CRH. The Outer Core Group had not made a decision and had asked for a member of the Inner Core Group to make a presentation to an Outer Core Group meeting to explain the revised pathway and clarify the benefits of this in relation to managing COVID and more generally in terms of pathway improvement. A timeline for attendance was awaited. AN suggested that this may be a better pathway for patients regardless of COVID. AB advised that the Outer Core Group wanted to explore if this was a better pathway and if it could be sustained as a longer-term transformation direct to Orthopaedic surgery or was it only possible due to the fact that Orthopaedics were not currently carrying out elective work.

The Committee **SUPPORTED** the decision made by the Outer Core Group.

21/20 MANAGEMENT OF TYPE 1 RESPIRATORY FAILURE IN PATIENTS WITH COVID-19

It was noted that on 14 May 2020 the Outer Core Group had considered a report submitted by the Inner Core Group that provided information in relation to CHFT treatment protocols for respiratory failure in COVID-19 patients. The Outer Core Group had sought to understand if there had been a change in treatment protocol and the impact of this on mortality rates. The Outer Core Group had considered the information provided and requested further information to be provided for consideration at a meeting of the Outer Core Group on 28 May 2020. AB confirmed the requested information had been received from the Medical Director, which would be discussed by the Outer Core Group this week.

DS asked what the current position was regarding CPAP equipment and if the Trust had a sufficient supply of equipment and whether training for staff had been provided. AB agreed to request an update on this from the Inner Core Group.

The Committee **SUPPORTED** the actions taken by the Outer Core Group.

22/20 UPDATE – TEMPORARY RELOCATION OF THE MACMILLAN UNIT

AB reminded the Committee that the Outer Core Group had requested an update from the Inner Core Group regarding the decision previously made for the temporary relocation of the Macmillan Unit to Huddersfield to provide the Chemotherapy service from the Green Lea Unit. This update had been provided and recommended the re-opening of the Macmillan Unit from 1 June 2020. This proposal had been supported by the Outer Core Group, although assurance was requested that communication with patients would make clear that should there be a further COVID-19 surge it may be necessary to move back to a single site. AB confirmed that the Outer Core Group had re-emphasised the importance of staff engagement. It was noted that the trigger to revert back to one site was a minimum level of staffing to provide a safe service and would only be done if absolutely necessary.

The Committee **SUPPORTED** the actions of the Outer Core Group.

23/20 UPDATE – TEMPORARY CONSOLIDATION OF AMBULATORY CARE SERVICE

AB reminded the Committee that the Outer Core Group had requested further information regarding the temporary consolidation of the ambulatory care service at Huddersfield, implemented earlier in the pandemic. The release of 15 beds at CRH for COVID-19 patient provision had not been required and in fact there were a large number of unoccupied beds across sites. It was noted that complex planning was taking place across the Trust with a view to starting non-COVID preparation and winter demand planning, the key to which was having facilities to zone patients between COVID and non-COVID and ensuring social distancing. The Inner Core Group wished to retain the change until the modelling had been completed as the 15 beds may be required for zoning and segregation of capacity. The Outer Core Group had requested the following further information by 22 May 2020:

- evidence that all possible options for provision of the 15 beds required to re-open ambulatory care at CRH had been exhausted and accommodation was identified as soon as possible
- clarification of the timeline for completing the bed plan review at CRH to confirm zoned / segregated areas
- what contingency plans were in place to re-open ambulatory care at CRH – should there be an increase in ambulatory activity at HRI that requires this to be quickly implemented on the grounds of safety for patients and staff.

The Committee **SUPPORTED** the actions taken by the Outer Core Group.

24/20 UPDATE – TEMPORARY SUSPENSION OF THE HUDDERSFIELD BIRTH CENTRE

AB reminded the Committee of the proposal to temporarily suspend services at the Huddersfield Birth Centre, which had previously been supported by the Outer Core

Group, due to insufficient staffing predictions and in line with Royal College guidelines. The Outer Core Group had discussed the staffing levels and whether these aligned with other sources of staffing data. It had transpired that staffing numbers had not fallen to a level to necessitate closure, therefore the temporary suspension did not take place. The Outer Core Group asked for further information on the position regarding home births. The data received showed an increase during April of home births. DS asked if further increases in home births could be sustained going forward. AB advised that the total staffing availability was managed across the two birth units and home delivery. If staffing levels fell, in line with national guidelines and the previous decision made by the Outer Core it may be necessary to consolidate births to CRH.

The Committee **SUPPORTED** the actions of the Outer Core Group and noted the position on home births.

25/20 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.

In the light of further updates, it was suggested that the Committee should meet sooner than 18 June, after 4 June Board meeting. If updates were not available by this time the meeting could be stood down.

26/20 DATE AND TIME OF NEXT MEETING

A date for the next meeting would be identified **(now 5 June at 12.00 pm)**. A further meeting would be held on Thursday 18 June 2020 at 1.00 pm (via Microsoft Teams).

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Friday 5 June 2020 - 12.00 – 1.00 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

27/20 APOLOGIES FOR ABSENCE

There were no apologies for absence.

28/20 MINUTES OF THE LAST MEETING

The minutes of the last meeting held on 26 May 2020 were **APPROVED**.

Matters Arising:

Knowledge Portal Access - AN advised the Committee that he had received examples of data available from the Knowledge Portal. He felt this would be helpful going forward in terms of identifying backlogs, A&E performance, etc. Once reviewed AN would share the information with the Committee if he felt it to be of value.

29/20 CONSOLIDATION OF CHILDREN'S ACUTE SERVICES

AB gave an update of the decision made by the Outer Core Group on 28 May 2020 regarding the proposal to consolidate the Children's Acute Services on the Calderdale site in the event of a shortage of paediatric middle grade medical capacity. The Outer Core had been mindful of potential safeguarding issues and the CQC recommendation at the last inspection regarding our configuration of children's services across the two sites. The Outer Core Group had therefore not supported this proposal and made a number of requests back to the Inner Core Group, including sharing the proposal with the CQC for their advice and exploring the possibility of diversion of paediatric surgery to other centres. A verbal update had been provided by the Inner Core Group stating that it had not been necessary to progress the proposal at this time. The Inner Core Group had therefore recommended this proposal be suspended/'parked' to enable it to focus on reset and recovery capacity modelling.

The Outer Core Group recognised that whilst the proposal was not currently being progressed it may be necessary to revisit these proposals to mitigate risks in the provision of paediatric services in a potential future crisis situation where delivery of normal standards of care was not possible. In this scenario the view of the CQC to inform decisions on the proposals would still be needed. The Outer Core Group requested the Inner Core Group seek CQC advice now rather than wait until a crisis situation emerged. The Outer Core Group would follow-up on this at a future meeting.

The Committee **SUPPORTED** the decision made by the Outer Core Group.

30/20 ED MINOR INJURY SERVICE

AB gave an overview of the current position. On 7 May 2020, the Outer Core Group had not supported the proposal and had asked for a member of the Inner Core Group to make a presentation to an Outer Core Group meeting to explain the revised pathway and clarify the benefits of this in relation to managing COVID and more generally in terms of pathway improvement. It was noted that the proposal was not currently being progressed. The Outer Core Group discussed the proposal further on 28 May 2020 and recognised the potential benefits of the proposed pathway and requested that this be explored further as a service redesign opportunity through the Business Better Than Usual (BBTU) programme of work.

It was noted that BBTU engagement was almost concluded and the emerging themes had been briefed to the Board of Directors on 4 June 2020. A consolidated report would be available within the next two weeks. It was noted that it was likely this would inform a programme managed approach to improvement replacing the CIP Turnaround Executive (TE). This would retain the positive elements of TE regarding programme monitoring, reporting, and director accountability and would focus on taking forward new ways of working and transformation. A further review would be anticipated in September 2020.

The Committee **SUPPORTED** the decision made by the Outer Core Group.

31/20 MANAGEMENT OF TYPE 1 RESPIRATORY FAILURE IN PATIENTS WITH COVID-19

AB provided an update from the Inner Core Group. The Outer Core Group decision on 28 May 2020 was to formally note and receive the technical information provided by the Medical Director regarding the management of respiratory failure in patients with COVID-19.

It was noted that the Outer Core Group would review the mortality position in the Autumn, or subject to any further surge. It was recognised that the data may be inconclusive due to the low number of patients in ICU. AN had been made aware that there had been a significant number of COVID deaths outside of ICU and felt that a broad analysis of the mortality pathway would be helpful. DS advised the Committee that the Quality & Workforce Committee had received a review of 10 COVID deaths, escalation to Coronary Care (CC) and the decision-making

process. DS agreed to share the report. AM advised the Committee that the Board of Directors would formally receive this report at its meeting on 2 July.

The Committee **SUPPORTED** the action taken by the Outer Core Group.

32/20 UPDATE – TEMPORARY SUSPENSION OF HUDDERSFIELD BIRTH CENTRE

AB reminded the Committee of the proposal to temporarily suspend services at the Huddersfield Birth Centre, which had previously been supported by the Outer Core Group, due to insufficient staffing predictions and in line with Royal College guidelines. It was noted that the proposal had not been enacted.

The Outer Core Group had noted the increase in the number of home births in March (5) and April (15) 2020, suggesting a trend that mothers were selecting home births during this period.

The Committee **NOTED** the position on home births.

33/20 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.

34/20 BOWEL CANCER SCREENING

It was noted that this service had restarted in collaboration with the Independent Sector (IS). The current IS contracts were in place until the end of June. However, nationally these contracts were being extended for a further two months. AB advised the Committee that a national operating framework with more definitive guidance was anticipated, against which we would consider our stabilisation and reset plans. It was recognised that although this could provide an opportunity to help with backlog, the financial envelope was as yet unknown.

It was noted that the Harrogate Nightingale hospital was currently being used for CT scanning but it was not yet known if CHFT would need to use this facility.

35/20 GOVERNANCE

AN asked if it was planned to retain the Inner Core/Outer Core governance model. AB advised the Committee that this was an emergent discussion at present, ie refreshing TE into a BBTU programme managed approach, how to embed and maintain new ways of working and a framework to rebase our financial operating model. There was no expectation of relaxing the current governance arrangements in light of the potential for a further surge and winter pressures. It was noted that the current structure was designed to enable rapid crisis response. AN said it was important to collectively consider Board/NED oversight, particularly the cultural change element of new ways of working. AM advised the Committee that the

governance reset work would be discussed at the Private Board of Directors' meeting in July.

AB advised the Committee that the Outer Core Group had discussed the reset and stabilisation plan presented to the Board of Directors as it had a support role to the Inner Core Group, ensuring that the key elements of EQIA/QIA, digital impact assessment, communication, etc were at the forefront of their plans.

36/20 DATE AND TIME OF NEXT MEETING

The next meeting would be scheduled in due course via Microsoft Teams.

Calderdale & Huddersfield Solutions Limited

1 Year Business Plan 2020 / 21

Introduction

Purpose of this Business Plan

This Business Plan sets out how Calderdale and Huddersfield Solutions Limited (CHS) will deliver its company objectives and increased services for 2020/21.

Background

In March 2018 the Trust approved the establishment of Calderdale and Huddersfield Solutions Limited (CHS) as a wholly owned subsidiary, which would become part of the CHFT Group. CHS went operationally live on 1st September 2018.

The last 12 months , we have had some challenges and also with some successes:

- Managing Director, Lesley Hill left the company in July 2019 and new Managing Director Stuart Sugarman commenced in September 2019
- Supported the Trust during the Coivd19 pandemic through the PPE and Equipment group; and acted as link with ENGIE/ISS at CRH
- Achievement of CHS KPIs
- Raising the profile of climate change within the Trust
- Facilitated quarterly meetings of the WYAAT Estates & Facilities Group (maintained a Whats App group during Covid)
- Delivered a profit for CHS and a £120k contribution to the Trusts charity
- Moved our waste contract from Mitie to Stericycle contract saving 150k pa
- Won the commercial tender for Acre Mill and successfully integrated the contract and staff into CHS.
- Transfer of the B-Braun decontamination contract to CHS, so we manage the staff, working group and the novated contract
- Completing numerous land disposals generating £3.5 m capital and completing the Elland lease to bring THIS and our community transport team under 1 roof.
- Pushed forward with the Scan 4 Safety agenda for the Trust, introduction of Asset tracking, recording of observations into EPR and active temperature monitoring. Moving maintenance contracts management from Divisions into CHS, improving compliance of medical devices. Working with WYAAT, regional and national medical engineering groups
- Worked closely with the WYAAT PPE and Procurement work-streams throughout the Pandemic and played a big role in the mutual aid position for the region and wider NHS. Supported the National NHS Improvement Programme for PPE and CHS procurement team became/are currently the Lead for procurement of Eye Protection across the NHS.
- Successful implementation of the new IT system and subsequent move of premises for the Equipment service,
- Received re-accreditation for CIMs (Cleaning Industry Management Standard)
- Continued with our Spotlight Monthly Awards
- Commenced a bi-annual Customer Survey, along with the continuation of the weekly patient surveys
- Held a 1st year celebration event for our staff and colleagues
- Set up and maintain a company Linkedin page

CHS Objectives for Year 2020/2021

Our Vision	***Together we will deliver outstanding compassionate care to the communities we serve***			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals (The result)	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
Our response	We will work alongside CHFT to develop the reconfiguration design and build process	We will develop a plan to complete more in-house maintenance on medical equipment to improve the service. We will develop and deliver a new Climate Change and Sustainability Policy.	We will tightly manage our sickness / absence with an aim to work towards achieving a target of 4% (inline with CHFT target)	We will review and implement our Commercial Strategy and Commercial Business Plans for 2020 / 21. Including promotion of CHS through social media and internet / intranet sites and brand establishment.
	We will relocate our community equipment service to a new site in Elland to ensure the service is fit for future service and development	We will improve medical equipment tracking through Asset tagging, Temperature Monitoring and improved asset disposal systems	We will continue to develop our staff and ensure they have all the skills and knowledge to fulfil their roles.	We will deliver the agreed profit target for 2020/21 We will deliver our agreed Cost Improvement Target (CIP) for 2020/21 We will deliver financial plan
	We will complete an option appraisal with CHFT of the current transport model service to propose changes to reflect new ways of working	We will ensure all our Cleaning Staff are trained to BICS standard methodology and hold a licence to practice, which will further improve the standard of cleaning	We will improve staff morale and inclusion and improve the appraisal experience for all staff, this will involve communication, staff surveys, action plans engagement, thank you cards and monthly recognition schemes	We will improve some of our services that are above the median cost in Model Hospital.
	We will deliver all KPIs and work towards further improvement. We will also ensure all reverse KPIs are delivered and CHS are receiving the support required from CHFT	We will assist CHFT throughout the COVID 19 pandemic and review our learning from this experience to provide improvements for the future, particularly in relation to safety and potential future pandemics.	We will ensure there is Commercial Development Programme in place for the company Senior Management Team	We will complete the LED lighting projects for CRH & HRI to improve the environment and provide efficiencies
	We will complete actions following audits and surveys with our Customer (CHFT) and patients to improve services	We will deliver and have robust CHS & CHFT Annual plans for Fire & Health & Safety in place that align with CHFT requirements	We will ensure all positions are filled and staff are developed to further improve the Medical Engineering / Decontamination Services.	We will review our utility contracts to find efficiencies

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NHS
Calderdale and Huddersfield
NHS Foundation Trust

Complaints Handling Policy

Version 3

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Document Summary Table		
Unique Identifier Number	G-106-2015	
Status	Ratified	
Version	3	
Implementation Date	April 2015	
Current/Last Review Dates	March 2020	
Next Formal Review	March 2023	
Sponsor	Executive Director of Nursing	
Author	Head of Legal Services and Complaints	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committee		
Board of Directors		
Executive Board		11 June 2020
Consultation Committees		
Committee Name	**Committee Chair**	**Date**
Patient Experience and Caring Group	Deputy Director of Nursing	21 May 2020
Other Stakeholders Consulted		
N/A		
Does this document map to other Regulatory requirements?		
Care Quality Commission		
NHS England Complaints Policy (2017)		
Document Version Control		
Version no	*Details of review/alterations, rationale for document etc*	
1	This policy used to form part of the Learning From Experience policy and has been extract to form a standalone policy. This policy has been updated to reflect our current processes and national guidance.	
2	Updated to reflect current practice and 3 gradings for complaints. Addition of information on handling habitual and persistent complainants, cross divisional complaints.	
3	Full Review	

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Appendices

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1. Introduction

This policy is intended for use across Calderdale and Huddersfield NHS Foundation Trust (CHFT), which includes Calderdale and Huddersfield Solutions Limited (CHS). Where responsibilities state all staff, managers senior managers and directors, this also includes CHS staff groups.

This Policy describes the requirements and Trust procedures for the investigation and management of improvements, suggestions, concerns and complaints, received across CHFT.

CHFT views any complaint as an extension of our service user's care and the Trust is therefore committed to having an effective procedure in place to handle all concerns and complaints. The Trust will take an active approach to seeking people's views, dealing with complaints and using the information received to learn and improve both the experience of our patients and the quality of the service we provide.

Where it is not possible to rectify a problem, we will provide an open, accountable and effective complaints service. All concerns and complaints will be dealt with on an individual basis, and will be investigated fully, transparently and honestly in a timely manner and where required in partnership with other agencies. Any suggestions and improvements will be shared across the Trust via the Divisional Boards to encourage learning.

CHFT recognises that service users and their representatives have a fundamental right to raise concerns about the services they receive. Accordingly, it is expected that staff will not treat service users and their representatives, unfairly as a result of any complaint or concern raised by them. Any complaints, by service users or their representative, of unfair treatment as a result of having made a complaint will be investigated as a separate complaint and appropriate action will be taken.

We support the Parliamentary and Health Service Ombudsman's Principles of Good Complaints Handling (2009), My Expectations (2014) and the NHS Constitution which includes a number of patient rights relating to complaints. In summary, these include patients' rights to:

- Have their complaint acknowledged and properly investigated.
- Discuss the manner in which the complaint is to be handled and know the period in which the complaint response is likely to be sent.
- To be kept informed of the progress and to know the outcome including an explanation of the conclusions and confirmation that any action needed has been taken on.
- Take a complaint about data protection breaches to the independent Information Commissioners' Office (ICO) if not satisfied with the way the NHS has dealt with this.

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1.1 Who this policy applies to:

This policy applies to all permanent, locum, agency, bank and voluntary staff of CHFT and any person or persons working in a contractor role acting for or on behalf of CHFT. CHFT employees work very hard to get the job right first time; however, sometimes mistakes can occur. As a CHFT employee you need to follow this policy this policy so that CHFT can ensure compliance to best practice and legal obligations to demonstrate that:

- any service users of CHFT, their family, or members of the public are given the opportunity to seek advice, raise concerns, and/or make a complaint about any of the services it provides
- that a person who raises a complaint, receives a high-quality response in a timely manner
- lessons learned from complaints are acted upon and shared throughout the organisation to improve standards of care and prevent avoidable harm/experience
- complaints are investigated and managed in line with:

The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

  - www.opsi.gov.uk/si/si2009/uksi_20090309_en_1
  - the Parliamentary and Health Service Ombudsman's (PHSO): My expectations for raising complaints and concerns 2014 http://www.ombudsman.org.uk/myexpectations

1.2 What is covered by this policy:

This policy covers suggestions, improvements, concerns and complaints made by service users and their representatives.

1.3 Complaints dealt with under this policy:

A complaint can be made to CHFT about any matter reasonably connected with the exercise of its functions including in particular:

- care or treatment provided
- anything to do with the hospital or healthcare environment
- any member of staff in relation to the care and service they provide
- how services are organised if this has affected treatment or care
- complaints about the CHFT's staff or facilities relating to the care provided to any patient in a private pay bed (but not to the private medical care provided by the Consultant outside their NHS Contract)
- care, treatment or an establishment that has been commissioned by the Trust to provide care on behalf of the NHS

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1.4 Complaints that cannot be dealt with under this policy are those:

- Made by a local authority, NHS body or independent provider (service – service)
- Relating to services not provided by CHFT
- From any current or former NHS employee about any matter relating to their employment
- Requests which are made under a subject access request under the General Data Protection Regulations or a request for information under the Freedom of Information Act
- Which are, or have been, investigated by the Health Service Commissioner under the 1993 Act

NOTE: Where complaints are received from General Practitioners regarding a patient, and the general practitioner has the consent of the patient to make the complaint on their behalf; then the complaint will be dealt with under this policy. Where the general practitioner does not have the consent of the patient or wishes to raise concerns about a service then the Patient Advice and Complaints Service/Divisional Team will deal with this outside of NHS Complaints Regulations.

1.5 Who can complain under this policy:

The Local Authority, Social Services and NHS (England) Complaints Policy (2017) and the Good Practice Standards for NHS Complaints Handling (September 2013) specify that complaints may be made by:

- a person who receives or has received services from CHFT; or
- any person who is affected or likely to be affected by any action, omission or decision of CHFT
- a person who is acting as a representative of:
  - a person who has died
  - a child
  - a person who is unable to make the complaint themselves because of lack of physical incapacity or lack of mental capacity
  - any individual who has otherwise asked the representative to act on their behalf

1.6 Time limit for making a complaint under this Policy

The Local Authority, Social Services and NHS Complaints (England) Regulations 2009 require that a complaint must be made within twelve months of:

- the date on which the matter which is the subject of the complaint occurred; or

- the date on which the complainant became aware of the matter which is the subject of the complaint.

Where a complaint is made outside this time limit the Head of Legal Services and Complaints / Assistant Patient Advice and Complaints Manger may exercise discretion to waive the time limit where it can be demonstrated, and satisfied that:

- the complainant had good reasons for not making the complaint within the time limit; and
- providing it is still possible to investigate the complaint effectively and fairly.

NOTE: Complaints made outside the established time limits can prove difficult to investigate and extremely problematic to resolve, not least because of the inevitable doubts over memories of events some time previously. This is a relevant factor to be considered in determining whether it will be possible to investigate a 'late' complaint effectively.

If it is not possible to waive the time limit and the complaint is not accepted into the Complaints Procedure, an explanation of this will be provided to the complainant.

2. Purpose

The purpose of the policy is to make sure CHFT procedures are fully compliant with the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 meets NHS Resolution (NHSR) Risk Management Standards for Acute Trusts (RMST) and Care Quality Commission (CQC) Outcome 17 and supports Sections 2a and 3b of the NHS Constitution.

Our approach is to consider issues thoroughly and objectively and share our findings openly, honestly and in a timely manner. This policy and procedure is based on the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 and Principles of Good Complaint Handling from the Parliamentary and Health Service Ombudsman (PHSO).

2.1 Policy Aims

The aim of this policy is to provide all those involved in the complaints process with a clear understanding of CHFT's expectations and requirements. The Trust approach to managing concerns and complaints will be to listen and respond to concerns raised by service users and/or their representatives, to learn from their experiences and improve services accordingly. CHFT's arrangements for the handling of complaints will ensure that:

- Complaints are dealt with efficiently
- Complaints are properly investigated
- Complainants are treated with respect and courtesy
- Complainants will be involved in decisions about how their complaints are handled and considered as far as reasonably possible
- Complainants will be kept updated on the progress of the investigations and if the response is delayed, complainants will be notified and advised when to expect the response will be completed by
- Complainants receive a timely and appropriate response, with an acknowledgement and apology where appropriate for any upset or distress caused
- Complainants are told the outcome of the investigation of their complaint and;
- Following completion of the complaint, action is taken if necessary to ensure lessons are learned and to improve the quality of service provided.

2.2 Key Principles

This policy sets out the following key principles in handling complaints and concerns:

- Complaints and concerns will be view as an extension of the care provided to the service user
- Complaints and concerns will be dealt with in a fair, flexible and conciliatory manner, encouraging open communication between all parties
- High standards of conduct are expected from all staff always to ensure that service users and their representatives will be treated respectfully, courteously and sympathetically
- The requirement to maintain confidentiality during the complaints process will be absolute (unless indicated otherwise); All service users and their families and carers will be advised how they can raise a concern or make a formal complaint via information leaflets and posters available on all wards and clinical service units and the internet
- All people who make complaints will be advised of the various independent support agencies that are available to assist them in making their complaint
- As far as reasonably possible, people who make complaints will be involved in decisions about how their complaints are handled and considered
- CHFT will aim to resolve complaints within CHFT as part of local resolution (first stage of the national complaints procedure), wherever possible
- Complainants receive a meaningful apology when appropriate
- CHFT will co-operate with other organisations when a complaint involves other outside organisations
- No person who makes a complaint will be discriminated against on the grounds of religion, gender, race / ethnicity, disability, age or sexual orientation or because they have made a complaint

- Violence, racial, sexual, verbal or any other forms of harassment are unacceptable and will not be tolerated on the part of staff or people who make complaints

2.3 Support

The needs of those affected are a primary concern for CHFT as part of its processes for the investigation of complaints. It is important that affected patients, staff, families and carers are involved and supported throughout the investigation.

Making a complaint can be daunting and evidence confirms many people who might wish to complain do not because they do not know how to or they find the process intimidating. The Independent Complaints Advocacy Service (ICA) has been established to assist people who wish to complain. It will aim to ensure persons who raise concerns have the support they need to articulate their concerns and navigate the complaints system so that their concerns can be resolved more quickly and effectively. The service can be accessed through a variety of routes including PALS and Complaints staff. It will advertise locally through a variety of means agreed with ICA Managers.

It is important to recognise that complaints investigations can have a significant impact on staff who were involved.

Staff involved in the complaints investigation process must be given support, which may include some or all of the following: Support from their line manager or professional lead, the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.

CHFT recognises that individual members of staff may experience higher levels of stress if they become the subject of a complaint. CHFT is committed to supporting staff through the complaints process by offering guidance and by recognising the opportunities for personal development that may arise from the outcome of complaints. Line managers have the primary responsibility for providing this support to staff and can draw on further advice and guidance from the Patient Advice and Complaints Department. Where necessary additional support, including counselling, can be arranged through the occupational health service. Staff also have access to support from their professional or trade union organisations.

CHFT is clear that the investigation itself is separate to any other legal and/or disciplinary process. CHFT will advocate justifiable accountability when required but will operate a policy of zero tolerance for inappropriate blame and those involved must not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of

involvement in the investigation process.

Staff who are unhappy with the way they have been dealt with under the complaint's procedure may raise the matter through the CHFT's Grievance Procedure

3. Definitions

Suggestion/Improvement/Concern: Issues raised which require assistance to reach a swift and satisfactory resolution, usually within 72 hours, but do not require formal investigation.

Complaint: According to the Department of Health a 'complaint' is an expression of dissatisfaction about the service which CHFT provides, for which a response must be provided.

4. Open and Honest

The core professional standards are set out in *Good medical practice for doctors* and in *The Code: Standards of conduct, performance and ethics for nurses and midwives*, *HCPC Code of Conduct, NHS Code of Conduct for NHS Managers* (2005) and *Nolan Principles* (2019); state that doctors, nurses and midwives must:

- Be open and honest with patients if something goes wrong with their care
- Act immediately to put matters right if that is possible; and
- Promptly explain to patients what has gone wrong and the likely long-term and short-term effects

NOTE: The Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) ran a consultation on new joint guidance to help doctors; nurses and midwives comply with their professional duty to be open and honest with patients about their care. The consultation is entitled 'Openness and Honesty when things go wrong: the professional duty of candour'.

4.1 Statutory Duty of Candour

On 1 October 2014, new requirements for a statutory duty of candour came into force for NHS bodies as part of wider regulations developed by the CQC in line with their strategy for 2013-2016, '*Raising standards, putting people first.'* The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to registered persons when they

are carrying on a regulated activity. The CQC can prosecute for a breach of parts 20(2) (a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action.

Further information can be found in CHFT Duty of Candour Policy 2015.

Failure to adhere to the values and principles set out by CHFT, in relation to complaints handling, may be subject to an internal investigation under HR processes.

5. Accessibility of Patient Advice and Complaints Service

Clear information on how to make a complaint must be made available to the public through leaflets throughout Trust premises and information on the Trust website.

All staff dealing with complaints must consider the needs of vulnerable people such as adults with learning difficulties, children, some older people or people with disabilities, (such as visual impairment or hearing impairment), and will offer support from relevant agencies to such individuals.

All staff dealing with complaints will consider the need for language or sensory support in order to make sure that the complaints procedure is accessible to all.

6. Consent

Where a complaint is made by a representative then they must demonstrate that they have the appropriate authority or consent to act.

Consent is not required from MPs when they act directly on behalf of a constituent as CHFT may assume that the MP has obtained sufficient consent to release relevant confidential information (see section 17 S1 2002 (2905)); however, consent is required when acting on behalf of a third party (e.g. complaint by a daughter on behalf of her mother being represented by the MP).

Where a complaint is made on behalf of a person who has died, The Patient Advice and Complaints Department will check that the person making the complaint is the deceased patient's next of kin or is acting with their authority. Where this is not the case, the Patient Advice and Complaints Department will obtain the consent of the next of kin in writing. In doing so, the Trust will offer the next of kin the opportunity to review the complaint that has been made

Where a representative makes a complaint on behalf of a child or a person who lacks capacity, prior to investigating the complaint CHFT staff will satisfy

themselves that there are reasonable grounds for the complaint to be made by the representative rather than by the child or the person who lacks capacity. CHFT staff will also satisfy themselves that the representative is conducting the complaint in the best interests of the person on whose behalf the complaint is being made. If not satisfied, the representative will be notified in writing of the reasons for refusing to investigate the complaint.

Young people aged 16 and 19 – unless there is clear medical evidence that they lack mental capacity, then their express authority should be obtained before responding to the complaint if it will involve disclosing confidential patient information.

Children under the age of 16 – if a complaint is made by a child who is 'Gillick competent' (i.e. of sufficient intelligence and maturity to consent to treatment), then their agreement should be obtained before responding to the complaint if doing so will involve disclosing confidential patient information. Young people are encouraged to have their own voice and will be supported to provide their own feedback be that positive or supporting the young person to make a complaint.

NOTE: Where a complaint is made on behalf of a child under the age of 16 who is not Gillick competent then no authority from the child will be needed to respond to those with parental responsibility.

7. Data Protection

Staff must always be mindful of the General Data Protection Regulations 2018 and their NHS responsibilities in terms of patient confidentiality, particularly where a complaint is made by a representative on behalf of another individual. Staff must also be aware that all documents generated in the course of a complaint investigation (including internal memoranda/comments etc) are generally liable to be disclosed under the General Data Protection Regulations or in any subsequent legal claim.

Complaint investigations will be conducted in a confidential manner and only those members of staff who need to be involved in the investigation will be, in order to protect patient and staff confidentiality.

On acknowledgment of the complaint, complainants will be informed that it may be necessary to access their health record and to disclose information within it to those staff conducting the investigation and involved in preparing the response.

8. Learning from Complaints

CHFT will learn from complaints by identifying trends at a local and strategic level, which will assist in the prevention and recurrence or more serious

incidents or other similar complaints occurring in the future.

Divisional Directors, Associate Directors of Nursing, Directors of Operations, General Managers, Matrons and Lead Investigators are responsible for preparing action plans arising from individual complaints and for ensuring that these are implemented. Action plans should cross reference to actions of other providers (e.g. other NHS Trusts or social services departments) where appropriate, with a link to quality improvement practices across CHFT.

Learning from complaints is a critical part of complaints management. Lead Investigators will be responsible for providing feedback, in respect of complaint outcomes, to appropriate individuals who can take action and ensure lessons are learned. Lessons are also required to be shared across relevant meetings at ward/department, Directorate, Divisional and Trust level.

Internally, this will be through the provision of reports to the Board of Directors on a quarterly basis, through the quarterly Complaints Report and by specifically highlighting reports from the Parliamentary and Health Service Ombudsman in these reports.

Any theme or issue recognised which poses an immediate risk to CHFT will be escalated to the relevant Executive Director outside of the normal reporting Schedule.

Each Division within CHFT will devise a structure framework for learning from complaints to ensure that all learning is shared across the Division.

9. Claims for Compensation

Requests for compensation should be processed in accordance with the CHFT's Claims Policy in line with CNST/NHSR procedures rather than through the Complaints Procedure.

10. Duties (Roles and Responsibilities)

Ultimately, all staff members within the Trust have responsibilities in relation to complaints management, with certain members of the Trust having specialist functions.

10.1 Board of Directors

The Board of Directors is accountable for ensuring that effective controls are in place to support effective complaints management and organisational learning.

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10.2 Chief Executive

The Chief Executive is the responsible person as detailed in the NHS Complaints (England) Regulations 2009. S/he is responsible for ensuring compliance with the arrangements made under these Regulations, and in particular ensuring that action is taken if necessary, in the light of the outcome of a complaint. This responsibility may be delegated as appropriate.

The Chief Executive will delegate responsibility for the signing of complaint responses to the following staff in the following order:

i. Deputy Chief Executive and Executive Director of Nursing
ii. Medical Director
iii. Nominated Executive Director

10.3 Deputy Chief Executive and Executive Director of Nursing

The Deputy Chief Executive and Executive Director of Nursing is responsible for complaints management within the Trust. S/he will report regularly to the Board of Directors through the Patient Experience Group, in relation to complaints activity and performance, and will liaise with other senior members of the Trust as required.

10.4 Head of Legal Services and Complaints

The Head of Legal Services and Complaints, under the guidance of the Assistant Director of Quality, is the senior manager with responsibility for complaints policy development and for managing the procedures for handling complaints in accordance with the regulations.

The Head of Legal Services and Complaints will ensure that:

- CHFT's complaints handling policy reflects national regulations and guidance
- Systems and processes are sufficient to provide the Chief Executive with assurance that robust arrangements are in place
- CHFT meets all performance standards in respect of complaints management
- Systems are in place to ensure that the Board of Directors, Chief Executive and managers throughout CHFT receive regular reports on key performance indicators and are made aware of trends in complaints so that they can take action through the relevant clinical governance and risk management processes
- An annual report on complaints is provided to the Board of Directors and published, to provide an assurance to the Board of compliance with Care Quality Commission outcome 17 and NHSR Risk Management Standards

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10.5 Assistant Patient Advice and Complaints Manager

The Assistant Patient Advice and Complaints Manager, together with Head of Legal Services and Complaints, supported by the Patient Advice and Complaints administrative staff, are responsible for implementing this policy.

The Assistant Patient Advice and Complaints Manager, together with Head of Legal Services and Complaints, will ensure that:

- all complaints that are received are triaged (Appendix ?)
- all allegations of abuse or negligence are reviewed in line with CHFT's Safeguarding Adults and Safeguarding Children Policies
- all complaints received are processed in line with this policy
- staff are supported through the complaints process
- appropriate responses to the required standard are prepared in conjunction with Divisional and Directorate staff, within the relevant timescales
- trends in complaints are identified and drawn to the attention of senior managers and regular key performance indicator and trend analysis reports are provided
- they provide support to front line staff in dealing with immediate situations and provide advice to all staff with regard to formal and informal resolution of complaints
- queries or concerns about draft responses are raised with the relevant Division so that an appropriate response is provided to the complainant
- A programme of staff training in complaints handling is developed and implemented across the Trust

The Assistant Patient Advice and Complaints Manager, together with Head of Legal Services and Complaints, will review and approve all complaint responses, with the assistance of the Clinical Governance Manager, prior to the response being prepare for signature.

10.6 Divisional Directors

Divisional Directors are responsible for ensuring that the standards referred to in this policy are followed for their Division. They will ensure that investigations are undertaken appropriately and in a timely manner. They ensure that the Trust does not suffer reputational or financial penalty due to maladministration of complaints.

Under the direction of the Deputy Chief Executive and Executive Director of Nursing, The Divisional Directors will ensure that their Directorates comply with this Complaints Policy and undertake appropriate investigation, using Root Cause Analysis as necessary.

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The Divisional Director will ensure that there is an adequate process within the Division for an appropriate investigator to be appointed.

The Divisional Director will:

- Quality assure all complaint responses to ensure that they answer all issues raised as honestly and as comprehensively as possible.
- Ensure an action plan is developed to complete any actions identified in the investigation
- Ensure compliance with action plans to improve service provision
- Ensure there is an agreement between their Divisional counterparts for the investigation of cross-divisional complaints.

The Divisional Director may nominate a colleague with the Divisional Triumvirate to undertake these duties.

10.7 Divisional Lead for Complaints

The Division will identify a lead for complaints to manage and assist with the investigation of patient complaints in line with this policy, instigating any immediate action required for reasons of health, safety and security. The Divisional Lead will be responsible for ensuring complaints are dealt with in a timely manner.

10.8 Lead Investigator

The Division will appoint a lead investigator for each complaint.

The Lead Investigator may delegate all or part of the investigation to a suitably qualified and/or experienced colleague but will retain overall responsibility for the quality and content of the investigation and complaint response.

The Lead Investigator will made and maintain contact the Complainant.

As far as reasonably possible the Lead Investigator will involve the Complainant in the investigation of the complaint.

The investigation will be overseen by the Lead Investigator and may involve collecting verbal or written statements from current or former staff, and examination of the relevant documentation and other sources of evidence.

Completing a written report summarising the investigation into all concerns raised and ensuring that the response covers all issues.

Provide a written overview to the investigation that evokes the tone and sentiment to be conveyed in the response.

Once the complaint response is completed, the Lead Investigator will ensure that any action and learning is progressed and developed and shared with the relevant staff.

Ensuring timescales within the investigation are met.

Meeting with Complainants.

Ensuring risk registers are maintained if any risks are identified and that any serious issues are escalated within the Division as necessary.

Ensuring staff involved in complaints receive feedback on the investigation and action plan.

10.9 Patient Advice and Complaints Department

The Trust's Patient Advice and Complaints Department will deal with enquiries and concerns from members of the public and will be the point of contact for anyone wishing to raise a concern orally away from the ward or department.

If the Patient Advice Team is able to provide a mutually agreeable solution to issues within 72 hours, or with the agreement of the individuals this will be recorded as a concern.

The Patient Advice and Complaints Department will also:

- Administer the CHFT's Patient Advice and Complaints Inbox
- Advise members of the public on the complaint procedure if contacted directly
- Register concerns and complaints received centrally on the CHFT's Information System
- Provide reports to CHFT on compliance with quality indicators associated with complaints
- Offer advice, guidance and training to groups where required
- Facilitate the process with regard to multi-agency complaints
- When required obtain consent from the patient or next of kin, when required

10.10 All staff

Frontline staff are usually best placed to address issues and complaints raised by those who use CHFT's services. By taking prompt and effective action many issues can be addressed without the need for recourse to the formal complaints procedure. This approach is better for the complainant and for staff. It reduces tension and conflict, demonstrates understanding and empathy and builds confidence in CHFT staff and services.

All staff have a responsibility to ensure that:

- They observe and comply with this policy and associated procedures;
- They proactively address issues raised by those who use CHFT's services in order to minimise the number of complaints.
- Where faced with a verbal concern they make every effort to rectify the problem immediately by:
- Investigating the issues and providing a response;
- Contacting the most appropriate person to find out the information required, if necessary seeking advice from their line manager;
- Passing the issue on to a named person and informing the complainant why they have done so, who this is and when they can expect a response.
- They co-operate fully with complaint investigation and resolution;
- They support the implementation of action plans arising from complaints.
- They protect the interests of adults at risk, young people, and children. Reference to the CHFT's Safeguarding Team is advised if staff are unsure about this aspect.

11. Severity Rating

All complaints will be allocated a severity rating of Green, Amber or Red using the likelihood and consequence matrix see Appendix 2.

12. Process for Complaints Management / Investigation

Verbal complaints received in wards and departments by staff will be addressed promptly and fully by those staff, involving more senior management within the Division as appropriate. This is the most effective method of dealing with complaints; it reduces tension and conflict, demonstrates understanding and empathy and builds confidence in Group staff and services.

Verbal complaints received by PALS will be addressed promptly and fully by those staff, involving more senior management within the Division as appropriate.

Written complaints or verbal complaints where a written response has been requested will be risk assessed by the Head of Legal Services and Complaints / Assistant Complaint Manager.

All complaints received by the CHFT will be acknowledged by the Patient Advice and Complaints Department (i.e. when a letter comes to the CEO, it is forwarded to the Patient Advice and Complaints Department same day and who will acknowledge the complaint). This will minimise delays and any confusion regarding appropriate process.

If the individual(s) who has raised a concern contacts the CEO office during an investigation, it will be referred back to the Patient Advice and Complaints Department, who will allocate an appropriate person to have a discussion with the individual(s)/ service user.

All formal complaints will receive a signed response letter.

A standard operating protocol for investigating complaints named 'Protocol for the Investigation of Complaints will be developed to company this policy and will be reviewed yearly and updated in accordantly.

13. Cross-Organisation Complaint Investigations

Please refer to CHFT's protocol for the investigation of Complaints.

14. Complaints linked to Incidents

Upon receipt of a complaint, or during the investigation of a complaint, it may become apparent that the incident has occurred.

Should the incident trigger the statutory Duty of Candour, the complaint will be investigated under the incident process and the complainant's concerns will be addressed within the incident investigation and Root Cause Analysis, as part of the statutory Duty of Candour.

Upon conclusion of an incident investigation, where the services users concerns have been addressed through the incident process, should the service user and/or family of the service user remain unhappy with the outcome of the investigation, their additional concerns will be investigated through the complaints process.

15. Unresolved Complaints

Where the Complainant is not satisfied with the response to a complaint, the Head of Legal Services and Complaints / Assistant Patient Advice and Complaints Manager will review the Complainant's additional concerns and decide what action, if any, will be undertaken to resolve the complaint.

Where the Head of Legal Services and Complaints / Assistant Patient Advice and Complaints Manager has concluded that CHFT has made all reasonable efforts to resolve the concerns of the Complainant, the complainant will be advised that they should raise the complaint with the PHSO.

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16. Responding to the Parliamentary and Health Service Ombudsman (PHSO)

The remit of the PHSO is to assess complaint cases where the local resolution has been unsuccessful. Once CHFT has forwarded contact details for the PHSO onto the complainant it is up to the complainant to pursue their case with the PHSO.

In circumstances whereby the PHSO contacts CHFT for information relating to a complaint that they have been asked to review, the following actions will need to be taken:

- The Complaints Department should contact the relevant service to advise;
- The service should provide all requested documentation and information to the complaints team within a timely fashion;
- The Complaints Department should provide the PHSO with the information requested within the timescale where practicable.

17. Habitual and Persistent Complainants

There are a small number of occasions when there is nothing further which can be done to assist a complainant to rectify a real or perceived problem. These complaints take up a disproportionate amount of staff time and resources and dealing with the complainants can cause undue stress to staff.

Such complaints are considered to be habitual or persistent, by virtue of being unreasonably demanding. Where a complaint meets two or more of the following criteria it may be defined as being a habital and persistent complainant.

- Persistence by the individual in pursing an issue or complaint after the NHS complaints procedure has been fully and properly implemented and exhausted
- Changing the substance of the issue or complaint, continually raising new issues or continually raising further concerns / questions whilst the complaint is being addressed or upon receipt of a response in order to prolong contact (new issues which are significantly different from the original complaint will not be included within this category and may need to be addressed as separate complaints)
- Unwillingness to accept documented factual evidence or to accept that facts can be difficult to verify if a long period of time has elapsed
- Will not identify the precise subject matter of the complaint
- Harassing any member of staff or being personally abusive or verbally aggressive or racially abusive (see CHFT's Violence and Aggression Policy) - Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second

criterion to be met and to suspend all contact with the complainant
- Threatening or using actual physical violence (see CHFT's Violence and Aggression Policy) - Meeting this criterion alone will be sufficient to determine the complaint to be unreasonably demanding without the need for a second criterion to be met and to suspend all contact with the complainant
- Meetings or face-to-face / telephone conversations tape recorded by the complainant without the prior knowledge or consent of other parties involved
- Unreasonable demands / expectations made and failure to accept these may be unreasonable
- Repeated refusal to follow alternative avenues open to the complainant (e.g. refusal to refer the complaint to the PHSO)

CHFT reserves the right to restrict and ultimately end communication on complaints that are classed as habitual and persistent. This approach will only be used after all reasonable measures have been taken to try to resolve the complaint through the NHS complaints procedure with, where appropriate, the involvement of independent advice, support or conciliation services.

It is accepted that in the initial contact a person making a complaint to the Trust may act out of character, for example aggressively, and allowances will normally be made for this. However, unacceptable behaviour that continues through several contacts will be considered against the background of this policy.

When the complaint has been identified as being habitual and persistent the complainant will be advised in writing that their actions are prejudicing the continued investigation of their complaint or that there is nothing further that the Trust can do to assist. The letter from the Patient Advice and Complaints Manager / Assistant Patient Advice and Complaints Manager will clearly identify why the complaint is unreasonably demanding and will list the circumstances in which the individual may legitimately continue to raise their concerns. This might include:

- explaining the complaints procedure and help that is available;
- imposing a time limit on further discussions;
- meetings or on drawing the complaint to a conclusion;
- declining contact with the complainant unless clearly pre-arranged;
- declining contact with the complainant either in person, by telephone, fax, letter or email, providing one form of contact remains open, or
- alternatively restrict contact to a third party

Where these actions do not bring about a change in behaviour and the complainant's behaviour continues, then a report will be prepared for the Chief Executive. The Chief Executive (or nominated deputy) will determine what further action may be taken and will advise the complainant in writing.

These actions may include:

- an agreement and code of behaviour for both parties to sign which sets out the circumstances in which the Trust will continue to investigate the complaint
- declining all further contact regarding the complaint
- Where appropriate pursuing a legal remedy

Even after the above steps have been implemented it is important to recognise that further contact from the complainant on different matters is not to be automatically considered unreasonably demanding, unless such contact is of a nature designed to consume staff time to such an extent that it prevents ongoing work and the provision of service to other individuals.

Withdrawal of habitual and persistent status may be achieved if the complainant demonstrates a more reasonable approach. The Chief Executive (or nominated deputy) will determine whether habitual and persistent status may be withdrawn. If this is the case the complainant will be notified in writing and normal contact will be resumed.

18. Complaints which involve Patients with a Learning Disability

Organisations have legal and statutory duty to ensure that children, young people and adults have equal access to services. This means providing specific support to people and families to ensure that they are not disadvantaged by issues relating to disability. These simple principles can help organisations and practitioners meet their duties and improve how they deal with feedback, concerns and complaints in health care, social care and education for autistic people, people with a learning disability and families:

To ask:
- The organisation asks people about their experiences and makes it easy for people to do this
- The organisation makes sure that the person, their family or advocate know how to give feedback, raise a concern and make a complaint
- People feel able to speak up when they have feedback, a concern or complaint. Everyone knows when a concern or complaint is a safeguarding or a criminal issue, and what must happen

To Listen:
- The organisation really listens to what has been said and is not defensive
- The organisation and staff have the skills to listen and understand what it feels like for the person

To Do:
- The organisation does something positive about it in good time and tells the person what they are doing to put it right

- The organisation learns from the feedback, concern or complaint and changes things so the service can improve
- The organisation improves its services by working with the people that use them, listening to and learning from people's experiences

There is a range of 'Ask', 'Listen', 'Do' resources for anyone who handles feedback, concerns and complaints. These resources help providers understand the issues that autistic people, people with a learning disability and families face. They also offer practical advice which can be used in staff training, for example, to understand more about reasonable adjustments and the difference they can make. These resources are available through the LD Matron.

The Trust must make reasonable adjustments for complainants with learning disabilities which include home visits, meeting in a safe place, easy read complaints information and having someone present to take notes or providing the complainant with an audio recording of the meeting.

19. Trust Equalities Statement

CHFT aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, race, disability, age, sexual orientation, religion or religious/philosophical belief or marital status.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

20. Monitoring Performance, Compliance and Effectiveness

Compliance with this policy will be monitored as outlined in the table below:

Criteria	Monitoring Mechanism	Responsible	Frequency	Monitoring Committee
Listening and responding to complaints	Compile reports using Datix information to include: Number of complaints received and compliance with the agreed deadline for complaint response; and analysis of themes	Head of Legal Services and Complaints	Monthly	Board Performance Report

	Summary of open complaints to Divisional Directors		Weekly	
Improvements made as a result of concerns/complaints being made	Compile report of changes in practice as a result concerns/complaints	Divisional Complaint Leads	Quarterly Complaints Report	Patient Experience and Caring Group Quality Committee

20.1 Annual Complaints Report

As detailed in section 18 of the Local Authority, Social Services and NHS Complaints (England) Regulations 2009 CHFT is required to produce an annual complaints report that:

(a) specifies the number of complaints which the responsible body received;
(b) specifies the number of complaints which the responsible body decided were well-founded;
(c) specifies the number of complaints which the responsible body has been informed have been referred to:
  (i) the Health Service Commissioner to consider under the 1993 Act; or
  (ii) the Local Commissioner to consider under the Local Government Act 1974; and
(d) summarise:
  (i) the subject matter of complaints that the responsible body received;
  (ii) any matters of general importance arising out of those complaints, or the way in which the complaints were handled;
  (iii) any matters where action has been or is to be taken to improve services as a consequence of those complaints.

The Trust has a duty to send a copy of the report to the Clinical Commissioning Group who commissions services from the Trust and also to ensure that this report is available to any person on request.

21. References

Supporting References and Bibliography:

Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

- Data Protection Act 2018
- Freedom of Information Act
- NHS Constitution (DH, 2009)

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- The Principles of Good Complaint Handling (Parliamentary and Health Service Ombudsman, 2008)
- Department of Health (2009) Listening, improving, responding: a guide to better customer care
- NHSLA Litigation Authority guidance about complaints
- My Expectations for Raising Complaints and Concerns (Parliamentary & Health Service Ombudsman, 2014)
- National Health Service Litigation Authority (2002). Litigation Circular No: 02/02: Apologies and Explanations, February 2002.
- NHSLA (2012) NHSLA Risk Management Standards 2013-14 for NHS Trusts
- Care Quality Commission Core Standards

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APPENDIX 1

RISK ASSESSMENT TOOL

The risk assessment tool adopts a 3-step process which first **categorises the consequences** of a complaint then **assesses the likelihood of recurrence** of the incidents or events giving rise to the complaint. Finally a **risk level is assigned** to the complaint.

Consequence Categorisation Table

The following table assists in determining how to categorise the consequence of a complaint or the subject matter of a complaint.

Category	Description
Serious	Issues regarding serious adverse events, long-term damage, grossly substandard care, professional misconduct or death that require investigation. Serious safety issues. Probability of litigation high.
Major	Significant issues of standards, quality of care, or denial of rights. Complaints with clear quality assurance or risk management implications or issues causing lasting detriment that require investigation. Possibility of litigation.
Moderate	Potential to impact on service provision/delivery. Legitimate consumer concern but not causing lasting detriment. Slight potential for litigation.
Minor	Minimum impact and relative minimal risk to the provision of care or the service. No real risk of litigation.
Minimum	No impact or risk to provision of care

Likelihood Categorisation Table

Likelihood	Description
Frequent	Recurring – found or experienced often
Probable	Will probably occur several times a year
Occasional	Happening from time to time – not constant, regular
Uncommon	Rare – unusual but may have happened before
Remote	Isolated or “one off” – slight/vague connection to service provision

Risk Assessment Matrix

Having assessed the consequence and likelihood categories using the tables above, the risk assessment matrix below can be used to determine the level of risk that should be assigned to the complaint.

RISK GRADING					
Consequence	**Likelihood of recurrence**				
	Frequent	**Probable**	**Occasional**	**Uncommon**	**Remote**
Serious	**HIGH**				
Major					
Moderate			**MEDIUM**		
Minor					
Minimum					**LOW**