Public Board of Directors 2 September 2021 - Items for Board Assurance

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1. Annual / Bi-Annual Reports

1. Medical Revalidation and Appraisal Annual Report

2. Emergency Planning Annual Report

Date of Meeting:	Thursday 2 September 2021
Meeting:	Board of Directors
Title:	Revalidation and Appraisal of Non Training Grade Medical Staff
Author:	Sue Burton, Medical Education
Sponsoring Director:	Dr David Birkenhead, Executive Medical Director
Previous Forums:	The Workforce Committee reviewed and discussed this report on Monday 9th August 2021

Actions Requested: The report is provided for assurance purposes.

Purpose of the Report

To update the Board on the GMC revalidation and appraisal compliance for non-training grade medical staff for 2020/2021.

Key Points to Note

As a result of COVID-19 the appraisal process was suspended by NHSE on 19th March 2020. The process was restarted on 1st October using a temporary revised appraisal format, however the need to complete an appraisal was not mandated. Likewise, the GMC suspended for 12 months revalidation recommendations due between 17th March 2020 and 31st March 2021. The report also includes as Appendix 1, A Framework of Quality Assurance for Responsible Officers and Revalidation (NHS, July 2021) which requires Board approval.

EQIA – Equality Impact Assessment

The completion of appraisals and the GMC revalidation process make an overall positive contribution to advancing quality in relation to colleague/patient safety across the NHS. The revalidation and appraisal process does not have a negative impact on equality for people with protected characteristics.

Recommendation

This report is submitted to the Board with the assurance that the agreed processes for GMC revalidation and appraisal, including the temporary revisions in light of COVID-19, have been adhered to. The Committee is asked to note the contents of the report.

BOARD OF DIRECTORS – THURSDAY 2nd SEPTEMBER 2021

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF 2020/2021

1. Executive Summary

The purpose of this report is to update the Board on the progress of the Trust's management of medical appraisal and revalidation. The report will cover the 2020/2021 appraisal and revalidation year (1st April 2020 – 31st March 2021).

The report content differs slightly to previous years due to the General Medical Council (GMC) temporarily adjusting the requirements of both appraisal and revalidation as a result of the COVID-19 pandemic.

Summary of key changes in light of COVID-19:

1.1 On 19th March 2020 the GMC, supported by NHS England and Improvement (NHS E&I) suspended all appraisals to allow doctors to concentrate purely on the immediate clinical challenge.

1.2 For any doctor missing an appraisal this was to be categorised as an 'approved missed appraisal' meaning that a missed appraisal due to COVID-19 would not impact upon a doctor's ability to revalidate at a later date if otherwise ready.

1.3 Revalidation recommendations were suspended by the GMC for any doctor with a revalidation date between 17th March 2020 until 31st March 2021. These doctors had their revalidation delayed for up to one year. If a doctor was already 'under notice' for revalidation (ie within 4 months of their revalidation date) **and** they had submitted sufficient information it was still possible for a revalidation recommendation to be made.

1.4 The GMC restarted the appraisal process from 1st October 2020. Appraisals were not mandated from this date and the approach taken was up to individual Trusts. We informed all doctors they could undertake an appraisal if they chose to. If they chose not to this would be classed as an 'approved missed appraisal'.

1.5 The GMC revised the appraisal format and content from 1st October 2020. The aim of the first appraisal following the pause would be to celebrate a doctors successes, provide support, and offer an opportunity for a confidential discussion, if needed, of their experiences of COVID-19. The revised format focussed less on evidence of Continuing Professional Development and involvement in quality improvement . The GMC have decided to keep this format of appraisal in place until 1st April 2022.

2. Background

2.1 Medical revalidation was launched in December 2012 to strengthen the way that doctors are regulated with the aim of improving the quality of care provided to patients. Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

2.2 The Trust has a statutory duty to support the Responsible Officer (Executive Medical Director) in discharging their duties under Responsible Officer Regulations and is expected that the board will oversee compliance by:

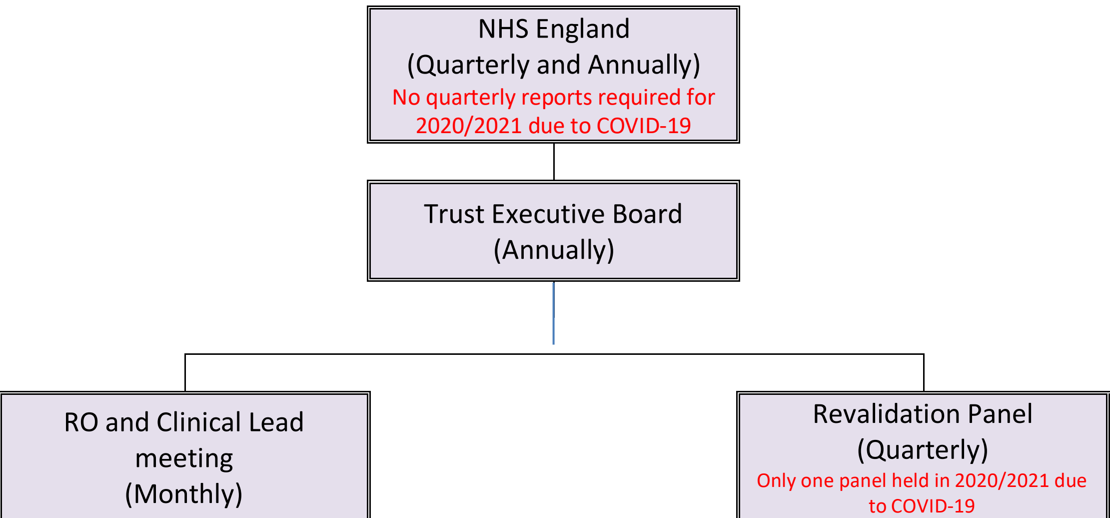
- monitoring the frequency and quality of medical appraisals in their organisations;

- checking there are effective systems on place for monitoring the performance and conduct of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process;
- ensure that appropriate pre-employment checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Governance Arrangements

3.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



3.2 GMC Connect

GMC Connect is the General Medical Councils database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

GMC Connect is managed by the Revalidation Office on behalf of the Responsible Officer. The Trust's Electronic Staff Record (ESR) is used as the main source in relation to starters and leavers.

4. Medical Appraisal and Revalidation Performance Data

Revalidation Cycles

4.1 As at 31st March 2021, 437 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust (as compared to 396 on 31st March 2020).

4.2 In the 2020/21 revalidation year (1st April 2020 – 31st March 2020) 78 non-training grade medical staff had been allocated a revalidation date by the GMC. Of these 53 had their revalidation date deferred by 12 months due to COVID 19.

4.3 In the 2020/2021 revalidation year (Year 8) revalidation recommendations were suspended from 17th March 2021 until 16th March 2021. It was possible to make a revalidation recommendation for those doctors who were already under notice for a recommendation prior to the 17th March. CHFT had held a Revalidation Panel on 9th March 2020 and so was able to make a number of recommendations indicated in the table below.

Revalidation Cycle (Year 8)	Positive Recommendations	Recommendation Deferred **
Year 8, Quarter 1 (April 2020 – June 2020)	24	1
Year 8, Quarter 2 (July 2020 – September 2020)	Postponed due to COVID-19	Postponed due to COVID-19
Year 8, Quarter 3 (October 2020 – December 2020)	Postponed due to COVID-19	Postponed due to COVID-19
Year 8, Quarter 4 (January 2021 – March 2021)	Postponed due to COVID-19	Postponed due to COVID-19
Total:	**24**	**1**

** The reasons for the deferral was insufficient evidence being presented for a revalidation recommendation to be made.

Medical Appraisal

4.3. Medical Appraisal underpins the revalidation process. Doctors are expected to complete five appraisals within the revalidation cycle. However, as a result of COVID-19 appraisals were suspended by the GMC between 19th March 2020 and 1st October 2020 after which time they were optional.

4.4 175/437 (40.05%) of non- training grade medical staff opted to complete an appraisal despite the requirement not being mandated. The majority of these were completed on the temporarily revised appraisal form developed by the GMC which focusses more on discussion than the requirement to evidence CPD etc.

5. Allocation of Appraisers

5.1 The Revalidation Office (part of Medical Education) allocates appraisers to appraisees and also allocates the month the appraisal should take place. This exercise still took place regardless of COVID-19 since appraisees still had the option to be appraised if they so chose.

6. **Quality Assurance of the Process**

6.1 The process used to monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal;
- The appraiser;
- The appraisal discussion

All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Revalidation Panel Quality Assurance Group. This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information).

6.2 The Clinical Appraisal and Revalidation Lead also routinely quality assures sample of appraisals submitted. This still took place for a sample of those appraisals completed.

6.3 **Access, security, and confidentiality**

Historical appraisal folders, supporting information and all correspondence relating to the revalidation processes are stored on the Trust network drive. Access to the drive is restricted to the Responsible Officer, the Clinical Lead for Appraisal and Revalidation and the Revalidation Office administrative support. All appraisals and supporting information are stored on the PReP system which is ISO27001 accredited, GDPR compliant, 100% IG Toolkit compliant. Access to appraisals is in line with the Appraisal Policy for non-training grade medical staff.

6.5 **Clinical Governance**

Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data and attendance at audit.

7. **Update**

a) PReP – Appraisal Form

The PReP appraisal form was updated to reflect revised GMC guidance in light of COVID-19. This will be in place until 1st April 2022 when the GMC will require us to revert to the previous format. The automatically generated e mail reminders for the completion of appraisals were suspended between March 2020 and 1st April 2021.

b) Internal Audit Report for Medical Revalidation (Audit Yorkshire)

The Trust was asked by NHS Audit Yorkshire to participate in an audit, the objective of which was to ensure the Trust's responsibilities are met for identifying doctors requiring revalidation and ensuring the Responsible Officer has sufficient and timely information with which to make a recommendation to the GMC.

We received a Significant Assurance opinion in the final report received in March 2021. Audit Yorkshire said that this outcome was reflective of 'robust systems and processes in place within the Trust.

c) A Framework of Quality Assurance for Responsible Officers and Revalidation (NHS 2021)

Attached 1 is the July 2021 NHS Framework of Quality Assurance for Responsible Officers and Revalidation. The report, submitted to NHS Revalidation, identifies how the Trust complies with NHS requirements for appraisal and revalidation.

8. Action Required of the Board

The report is provided for assurance purposes.

Dr David Birkenhead
Medical Director/Responsible Officer
September 2021

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

Designated Body Annual Board Report

Section 1 – General:

The board of Calderdale and Huddersfield NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes, Dr David Birkenhead (Executive Medical Director)

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: No specific actions Comments: None Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: No specific actions Comments: An accurate, up-to-date database is maintained by the Revalidation Office Action for next year: To maintain the database.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: No specific actions Comments: The Appraisal Policy for Non-Training Grade Medical Staff is reviewed and updated where necessary (the policy is currently being reviewed). Action for next year: To publicise and circulate the revised policy.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

> Actions from last year: The Trust participated in an audit, conducted by Audit Yorkshire.
>
> Comments: We have not been involved in a peer review but in 2020 NHS Audit Yorkshire undertook a review of the Trusts appraisal and revalidation processes for non-training grade medical staff. The Trust received a significant assurance opinion in the audit report received in March 2021. The outcome is reflective of 'robust processes in place'. The one action identified was to review the appraisal policy for non-training grade medical staff.
>
> Action for next year: The policy has been revised and the revisions are currently being considered by the relevant committees. We expect the revised policy to be approved soon.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> Action from last year: No specific actions
>
> Comments: The Revalidation Office offer one to one support and guidance for short term placement doctors. This includes an initial meeting and follow up support.
>
> Action for next year: To continue as present.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change.

Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: The Trust adopted the Appraisal 2020 model.
Comments: Whilst there has been no formal review of the revised form, anecdotal comments suggest it was well received and many of the doctors who chose to undertake an appraisal appreciated the time for a discussion which covered the impact of COVID-19.
Action for next year: We will continue using the 2020 appraisal model until 1st April 2022 unless advised otherwise by NHSE.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Not applicable
Comments: Not applicable
Action for next year: Not applicable

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: No specific actions
Comments: The policy was revised in April 2022. It has been reviewed by the Trusts Local Negotiating Committee and due to be considered by the Medical and Dental Pay and Conditions Committee. It will then be submitted to the Executive Board for final approval.
Action for next year: To publicise and circulate the revised policy.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: No specific actions
Comments: We do have sufficient trained appraisers and during the 2020 were able to train new appraisers.
Action for next year: To continue to ensure the Trust has a sufficient number of trained appraisers

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: No specific actions Comments: The Trust organises trained appraiser update sessions. Due to COVID-19 it was difficult to host these in 2020 Action for next year: To reinstate the full number of trained appraiser update sessions.

The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: No specific actions Comments: A sample of appraisals are quality assured by the Clinical Lead for Revalidation and Appraisal annually Action for next year: To continue with the quality assurance processes in place.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2021	**437**
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	**175**
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	**262**
Total number of agreed exceptions	**262**

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: No specific actions Comments: The Trusts Revalidation panel considers all submissions in a timely fashion and recommendations are made by the Responsible Officer in advance of the revalidation date. Action for next year: To continue with existing processes.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No specific actions Comments: Doctors are advised of the recommendation being made ordinarily on the day the Revalidation Panel meet. The Clinical Lead for Appraisal and Revalidation will ordinarily make personal contact with the doctors who are being deferred and they always receive written confirmation of reasons for the outcome. Action for next year: To continue with the existing processes

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: No specific actions Comments: The Trust has robust clinical governance processes (eg supporting doctors with revalidation and appraisal, continuous learning and improvement using mechanisms such as audit/review, patient feedback, investigating concerns, promoting freedom to speak, duty of candour etc) Action for next year: To continue to improve existing processes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: No specific actions Comments: All doctors are informed in advance of their appraisal of any clinical activity data available and details of any complaints, SUI's or incidents they may have been involved in. Action for next year: Too continue with existing processes.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: No specific actions Comments: The Trust has a robust policy in place which complies with national and local MHPS processes. Action for next year: To continue with existing processes.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: No specific actions Comments: The Board and Workforce Committee (a main Board sub-Committee) receives a regular performance report that captures employees where concerns are raised and formal processes instigated. The Board of Directors receive formal reports where individual doctors are excluded from the workplace. The Trust is compliant with national and local MHPS

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

processes with the Medical Director providing oversight. The Trust is assisting the Practitioner Performance Advice (PPA) service to develop a dashboard that captures individual NHS organisation engagement with it in relation to case management. The Trust has assessed its formal processes in accordance with the May 2019 'Improving People Practices' letter from the Chair of NHS Improvement, Dido Harding and has made changes, primarily the support offered to employees, to its formal processes.
Action for next year: To continue with existing processes

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: No specific action
Comments: We use the MPIT transfer from designed by NHSE for transferring information between Responsible Officers. We aim to complete and return these within 3 working days of receipt.
Action for next year: No specific action

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: No specific action
Comments: Safeguards are in place
Action for next year: No specific action

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: No specific actions
Comments: There are systems in place to ensure all appropriate pre-employment checks are undertaken. This is managed by the Workforce and Organisational Development team
Action for next year: No specific action

Section 6 – Summary of comments, and overall conclusion

We are pleased that despite COVID-19 a significant number of our doctors chose to participate in, and benefitted from, participating in an annual appraisal. We feel that this reflects the growing value of appraisal processes.

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

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Date of Meeting:	**Thursday 2 September 2021**
Meeting:	**Board of Directors**
Title of report:	**Annual Report:** **Emergency Preparedness Resilience and Response /** **Security Risk Management /** **Business Continuity Management Systems**
Author:	**Ian Kilroy, Resilience and Security Management Specialist** **Sarah Rothery, General Manager Corporate Ops**
Sponsor:	**Helen Barker, Chief Operating Officer**
Previous Forums:	
Actions Requested: • For Information	
Purpose of the Report	
The purpose of the Annual Report is to detail the work undertaken by the Resilience and Security Management team and through the SRGG for the period 1st Aug 2020 to 1st Aug 2021. It provides the Board of Directors with an update on the Trust's position in relation to Emergency Preparedness, Resilience and Response, Security Risk Management and Business Continuity Management Systems. The report highlights key achievements, key risks and informs of the priority areas to address.	
Key Points to Note	
Emergency preparedness, resilience and response is a key Trust priority alongside the safety and security of staff, patients and their carers, visitors, and property. The delivery of high standards of emergency preparedness ensures staff and organisational resilience. Safety and security work is critical to supporting the delivery of the highest possible standards of clinical treatment and care to our patients. Calderdale and Huddersfield NHS Foundation Trust (CHFT) is committed to improving the environment and personal security for those who access our services and for those who provide our services. NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. Emergency Preparedness, Resilience and Response (EPRR) is a programme of work that is underpinned by a set of a core standards. Demonstrating compliance to the core standards gives assurance that the Trust is prepared to respond to incidents whilst maintaining services. Staff working within the Trust have a responsibility to be aware of potential security issues and to assist in prevention of security related incidents and losses. We are always accountable for the security of ourselves and patients, visitors and colleagues and the property around us. The implementation of reduction programmes on violence and aggression, theft or damage across the Trust will lead to resources being released for the	

delivery of clinical care, contributing to the production and maintenance of a safe environment for the delivery of our services.

CHFT is a category 1 responder under the Civil Contingencies Action 2004 (CCA 2004) so that it can perform its critical activities in the event of an emergency or business interruption. CCA 2004 states Categorised 1 responders are required to: -

- Assess the risk of emergencies occurring and use this to inform contingency planning.
- Put in place emergency plans.
- Put in place a business continuity management led process to identify and mitigate risks.
- Put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency. Share information with other local responders to enhance co-ordination.
- Co-operate with other local responders to enhance co-ordination and efficiency.

The contents of this report reflect the commitment of the Board to achieving the safest possible environment from which to deliver high quality health and care services. It details the work conducted by the Resilience and Security Management team in collaboration with other members and teams within the organisation for the period 1st Aug 2020 to 1st Aug 2021, reflecting on the situations that have occurred during this reporting period.

EQIA – Equality Impact Assessment

The Annual Report aims to implement 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.

Recommendation

It is recommended that the Board of Directors:

Note the information provided within the Annual Report

Annual Report of Emergency Preparedness Resilience and Response / Security Risk Management / Business Continuity Management Systems

NHS providers must plan for, and respond to, a wide range of incidents and emergencies that could affect patient health and delivery of care. Emergency Preparedness, Resilience and Response (EPRR) is a programme of work that is underpinned by a set of a core standards. Demonstrating compliance to the core standards gives assurance that the Trust is prepared to respond to incidents whilst maintaining services.

This report summarises the structures and governance in place to ensure we are ready and able to respond to any emergency, the key activities that have taken place and our compliance with the core standards

1. GOVERNANCE

To ensure a safe and responsive environment for the delivery of our healthcare services, the Trust has security and resilience governance arrangements in place.

Accountable Emergency Officer (AEO): The Trust's Chief Operating Officer is the Accountable Emergency Officer with strategic responsibility for EPRR across the Trust and for providing assurance to the Trust Board that the organisation continues to meet its statutory and legal requirements.

Non-Executive Director: The Chairperson of the Security and Resilience Governance Group (SRGG), with EPRR within their portfolio.

Deputy Chief Operating Officer: Leads operationally on Emergency Planning, Resilience and Response across the organisation.

General Manager for Central Operations: Holds accountability for the Resilience and Security Management Specialist team who provide security and resilience programmes to ensure Trust preparedness for incident response.

Resilience and Security Management Specialist: Provides expertise in resilience and security. The tactical lead for resilience and security preparedness programmes and operational lead for incident response across the Trust. Informs the AEO and General Manager of Trust compliance with core standards and ability to respond to emergencies.

Resilience and Security Support Officer: Supports the Resilience and Security Management Specialist to deliver specialist security and resilience programmes across the Trust, and the provision of administrative support.

Security and Resilience Governance Group (SRGG):
The Security & Resilience Governance Group (SRGG) meets bi-monthly and is in place to ensure that the Trust complies with the legal requirements of the Civil Contingencies Act as well as fulfilling its non-statutory obligations under NHS England's Core Standards for

EPRR. The SRGG routinely escalates or refers information through the Health & Safety Committee and to the Trust Board.

Following a suspension of the formal SRGG during the Covid response, the group has recently recommenced and the SRGG Improvement Plan 2021-22 has been reviewed. There was some deferment of policy renewals agreed corporately as part of the pandemic response plan, these are now being reviewed and new renewal dates being agreed.

Key business continuity plans have been kept updated and were central to the Trusts pandemic response however, following assessment some were allowed to have an extended review date, reflecting the priority requirement to respond to the pandemic and will now form part of the August 2021 to August 2022 work programme along with the requirement to ensure all guidance documents are up to date reflecting the rapidly changing environment and the high volume of guidance published over the past 12 – 18months.

Following the review, the priority pieces of work have been agreed and a revised template for Improvement Plan has been developed. A supporting rag-rating action plan is in place to show progress and completion dates of the individual pieces of work. This is being monitored by the SRGG and reported into Health & Safety Committee.

It should be noted that the revised template Improvement Plan 2021-22 has not yet been presented at the SRGG and will be made available at the September 2021 meeting.

2. COVID-19 GLOBAL PANDEMIC

The impact of the Covid global pandemic presented global, national, regional, and local challenges on healthcare services. Significant service changes to protect and save lives have and continue to be rapidly introduced through the release of national guidance.

Last year's annual assurance return required a different process than in previous years. Acute Trusts were requested to submit a statement of assurance to the relevant NHS England and Improvement regional head of EPRR by 31 October 2020. The Trust complied with this process.

All NHS organisations have an undertaking to review their response to the Covid pandemic and embedded learning into recovery planning and winter planning. CHFT has complied with this requirement

Incident Control Centre

In response to the Covid-19 pandemic, the Trust's Incident Control Centre (ICC) has made some fundamental changes to improve the management of incoming communications and the onward cascade of information on to the required people. The ICC inbox and mobile telephone was managed by the Resilience and Security specialist team 7 days a week during the early stages of the pandemic. The inbox was allocated as the single point of contact for Covid-19 related communications and 'guidance log' was developed to monitor the incoming and outgoing communications as well as providing assurance on the

completion of any required actions. Also set up was a CHFT Incident Control 'Team' on Microsoft Teams where meeting notes and action plans were filed for ease of access by management teams across the Trust.

The Trust's ICC processes have been continually refined through learning. Recently more stringent governance controls have been implemented around the follow up of actions, with a twice-weekly ICC administration meeting put in place to monitor the receipt and dissemination of information, and the follow up of any actions or next steps required. Any urgent information is also delivered in the daily Tactical (Silver) command and Strategic (Gold) command meetings.

3. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

NHS Core Standards for EPRR

As part of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework, providers and commissioners of NHS funded services must show they can effectively respond to major, critical, and business continuity incidents whilst maintaining services to patients. The NHS Core Standards for EPRR set out the minimum requirements expected of providers of NHS funded services in respect of EPRR.

The purpose of the NHS Core Standards for EPRR are to enable healthcare provider organisations across the country to share a common approach to EPRR. The standards allow co-ordination of EPRR activities according to the organisation's size and scope, providing a consistent and cohesive framework for EPRR activities.

Providers of NHS funded care must provide an annual assurance return for their compliance against the NHS Core Standards for EPRR. The current set of core standards was published by NHS England in a letter to Trust Emergency Accountable Officers on 22nd July 2021.

There are 48 core standards in the 2021-22 release to which the Trust must self-assess its compliance against each standard and rate its compliance.

A mandatory part of the EPRR core standards assurance return is a deep dive into a specific area. The subject area changes each year and the 2021-22 annual EPRR deep dive is on Medical gases and piped oxygen systems. This is in response to the Covid pandemic and provides an opportunity for NHS England to better understand the resilience of piped oxygen systems across healthcare providers. As a Trust delivering piped oxygen systems, we are required to complete the deep-dive exercise as part of the assurance return however we know this was an area of particular focus during the pandemic with a specific workstream established to monitor oxygen compliance. The full self-assessment against the core standards and the deep dive exercise will take place in September 2021 with submission required to the Local Health Resilience Partnership (LHRP) by 27th October 2021. CHFT compliance will be reported into the SRGG.

Where the Trust is partially or non-compliant to a standard, work will be undertaken to assess the risks, gaps and develop a priority action plan. The results of the core standards self-assessment will be discussed at a LHRP meeting in October 2021.

Training

The Covid-19 pandemic highlighted a need for further staff to be loggist trained to record events accurately and precisely through note taking and decision logs. Loggist training is provided by the Trust's Resilience and Security Support Officer and will be delivered and monitored as part of the SRGG action plan.

The on-call manager training was further enhanced to support CHFT resilience in operationally managing the acute and community sites during the pandemic with regular forums for learning now taking place and 'quick guides' are in development to support on-call teams. Notebooks have been issued to provide a specific log where all actions and decisions taken during incidents/on call shifts are logged. Several tabletop exercises are being planned which can be delivered through TEAMS to aid learning. In addition, E-learning is available on CHFT intranet page.

Monthly on-call manager training is now in place and quarterly director on call training has also commenced in early 2021. Both forums also give the ability for colleagues to share for learning purposes their input into challenging situations they may have experienced during on-call shifts. Feedback from colleagues on these sessions has been good.

Specialist Incident Response Plans

Calderdale and Huddersfield NHS Foundation Trust is a Category 1 Responder (Cat 1) under the UK's Civil Contingency Act (CCA) 2004. The Act imposes a clear set of roles and responsibilities on organisations with a key role to play in preparing for and responding to emergencies. As a Cat 1 responder the Trust is subject to the full set of civil protection duties and is required to prepare for emergencies in line with its responsibilities under the Act. This includes assessing local risks, implementing emergency plans and collaborating with other local responders to enhance the co-ordination and efficiency of emergency response. The SRGG governs the activity that the Trust carries out in relation to the development, monitoring and testing of incident response plans to keep it compliant and resilient as a Cat 1 responder.

1. A full review of all internal Business Continuity Plans (BCPs) took place following the first phase of the COVID pandemic. All plans are held centrally by the EPRR Team as well as with the services.
2. An NHS England / Yorkshire Ambulance Service (YAS) Hazardous Materials (HAZMAT) Audit has recently been issued for departments to self-assess against a set of standards. Leaders from both CHFT's Emergency Department's (ED) and the Resilience & Security Management team have worked collaboratively to develop a self-assessment process and submitted the audit to NHS England 1st July 2021. The results of the audit showed partial compliance due to the cessation of training/testing during the COVID pandemic.

4. SECURITY RISK MANAGEMENT (SRM)

Violence Reduction and Prevention Standard

NHS employers have a duty of care to protect staff from threats and violence at work. In January 2021, NHS England published the new Violence Reduction and Prevention Standard, which complements existing health and safety legislation. A process is currently underway to assess the Trust against the indicators within the standard.

All providers of NHS-funded care should have regard for the standard and are required to review their status against it and provide board assurance twice a year. The standard is a risk-based framework which applies the Plan, Do, Check, Act (PDCA) approach across multiple indicators. The Trust is required to rate its compliance against each indicator and supply supporting evidence.

A working group has been developed at CHFT to address the Violence Reduction and Prevention standard, and initial observations have been shared with the specialist group. Early indications demonstrates that the focus should be concentrating on training to ensure staff have awareness, prevent and deter routine violence and aggression episodes in the workplace and to consider elements of risk processes, management and identifying known high risk areas.

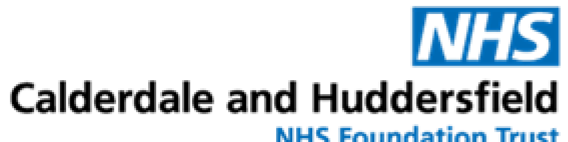
Staff have been issued with Clinically Related Challenging Behaviour Guidance through the Trust's intranet pages. This guidance focusses on the triggers and prevention of challenging behaviour to try to reduce the likelihood of violent and aggressive episodes.

A task and finish group has been established to concentrate on ligature risk assessments and inspections across hospital sites. 'Searching a Patient' Guidance is being developed to support staff to search for weapons, drugs and potential self-harm items for the protection of staff, patients and property. The principal focus is on legal requirements, justifiable and proportionate use of information to protect staff and patients. Revised Unacceptable Behaviour Response Guidance is also being developed to provide support to staff in the handling of and response to any unacceptable behaviour experienced in the workplace.

CHFT Security Training Programmes

Enhanced Conflict Management training has been delivered to groups of staff working in areas at higher risk of experiencing challenging behaviours, such as the Emergency Department reception staff. These sessions concentrate on identifying triggers, behaviour mechanisms and legal restraint. Concerns are discussed and specialist advice is given on the handling of difficult situations.

Lone Worker Personal Safety Training has been developed and a scheduled routine has been implemented for Community Division of CHFT. This focus is on Community based staff discussing policies, guidance and safety techniques and the information on the Internal Web Page on lone working.



The Trust's Chief Nurse has supported a collaboration with South West Yorkshire Foundation Trust (SWYFT) to develop a training package on assault avoidance and dis-engagement in high-risk areas at CHFT. A clinically led pilot was conducted prior to the Covid-19 pandemic which helped to raise awareness, understanding and techniques to improve confidence when delivering services to patients.

A task and finish group has also been established with Maternity Services colleagues to review the security arrangements for the protection against abduction of children. The group has agreed the principles of child abduction security guidance and will conduct a drill exercise to identify any weaknesses. The plan is to bring the outcome of this piece of work to the SRGG in October 2021.

Partnership Work - CHFT and West Yorkshire Police

The Trust has commissioned a Police Community Support Officer (PCSO) from West Yorkshire Police to support CHFT staff in making the environment safe for staff and patients. The PCSO has a presence across both hospital sites, frequently attends incidents and provides debrief and education to staff. The Trust also engages with the Violence Reduction Unit at West Yorkshire Police to share known risks, build on improving partnership communication and helping to keep the base safe.

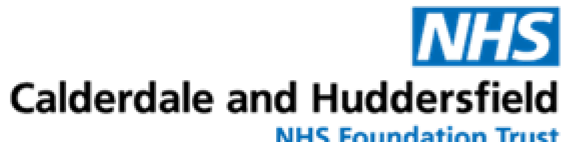
CHFT Security Projects and Groups

A security management ID card task and finish group has been established to challenge and strengthen the process of issuing an ID card with access to Trust areas to all new starters. It is also looking at the processes around those changing roles and Trust leavers. The outcomes are to assess the current situation, identify weaknesses and develop a report to provide suggestions for change at the SRGG in October 2021.

The Joint Security Operations Group meeting monthly to gather intelligence, discuss concerns and liaise with key groups to work together. The membership includes security, safeguarding teams and the clinical teams providing care to patients with dementia, mental health and learning disabilities. The specialist group considers key elements such as training, awareness, monitoring, and decision making when supporting patients in these vulnerable groups.

The update and expansion of the use of CCTV camera system at HRI has increased recording capacity and provided more footage in previous 'blind spots' at the site. The monitoring and capture of CCTV footage helps to assist the security team and the police to work to deter and prevent crime happening at our hospital sites keeping staff and service users safe.

The 'Design Out Crime' project is part of CHFT's reconfiguration plan to develop the new Emergency Department at HRI. Key areas of consideration include CCTV, automatic access control systems (AACS) and lockdown principles with a focus on increasing security and safety within the department. The project also has a focus on the implementation of a safe room, a key management system and a 'staff attack' alarm system to keep staff safe.



5. BUSINESS CONTINUITY MANAGEMENT

Business Continuity Exercise Planning and Advisory Discussions

The Resilience and Security Management Team have held Business Continuity discussions with colleagues in The Health Informatic Service to plan business continuity exercises for digital systems that are used by the Trust. Exercises have already taken place for EPR, SystmOne and K2, with others to be planned in 2022.

Discussions have also been had with Calderdale and Huddersfield Solutions Ltd (CHS) from which it is proposed to test the Estates Business Continuity Plan in September 2021 (abiding to social distancing rules). The Switchboard and General Office Business Continuity Plans are planned to be tested in December 2021, and Linen, Portering & Cleaning Services in February/early March 2022. Discussions will take place with the provider of servies to the CRH site to provide similar assurance

6. PRIORITY AREAS - AUGUST 2021 to AUGUST 2022

There are a number of risks that presently sit with EPRR and Security Management these are described below:

1. **Expired Policies & Procedures, Plans and Guidance**

The Resilience and Security Management team will prioritise the review of all expired documents as recommended by the review to ensure the Trust has a suite of in-date policies, procedures, plans and guidance relating to EPRR, Security and Business Continuity. This will be monitored through the SRGG.

2. **EPRR Core Standards**

The Resilience and Security Management team will ensure that the Trust is fully compliant with the 2021 – 2022 EPRR Core Standards and complete the 'deep dive' exercise on Medical gases/piped oxygen systems. The return will be submitted as required no later than 27th October 2021. Where the Trust is partially or non-compliant with a core standard indicator, an action plan will be put in to place to address the work needed to become fully compliant.

3. **Violence Reduction Standard**

The Trust is committed to minimising the risk of physical and non-physical assaults against its staff. The Resilience & Security Team will focus efforts on compliance against the Violence Reduction Standard and related workstreams that complement the Health & Safety Committee.

4. **Training and Dill / Exercises**

Recognising the challenges brought by the Covid-19 pandemic to carry out face to face training and exercises, when social distancing allows face to face training sessions and exercise / drill will re-commence to ensure the Trust is prepared in its response to incidents

and emergencies where it is deemed that the non face to face does not provide the required preparedness.

7. Summary

The Trust responded quickly and effectively to the Pandemic in 2021 evidencing a solid foundation of EPRR. Actions taken aligned with agreed policies and procedures and the pausing of any associated security or emergency preparedness activities was risk assessed and prioritised. The Trust has an excellent record of compliance with the core standards and no significant issues are expected from the self-assessment or deepdive.

All activities have now been restarted, clear plans are in place and the structures in place will ensure delivery of any outstanding policies or guidance and the ongoing training of colleagues.

2. CHS Managing Director's Report July 2021

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

JULY 2021

Calderdale and Huddersfield Solutions Ltd
Huddersfield Royal Infirmary · Trust Headquarters ·
Acre Street · Huddersfield · HD3 3EA

Web: www.chs-limited.co.uk

Company registration number 11258001 · VAT number 293 0609 00

1.0 Company Update

Verbal Update

2.0 Service updates

2.1. Estates

2.1.1 Capital Development / Backlog
The Learning Centre reprovision has been approved for the sub-basement floor at HRI. The package of works has been tendered and the team are currently looking at value engineering the scheme within budget. The team are hoping to appoint a contractor week commencing 16th August. It is anticipated the works will take 12-16 weeks to complete.

The decommissioning of the existing Learning Centre and Nurses Home is ongoing with asbestos removal and soft strip currently taking place. The demolition work commences on 12th September 2021, with the landscaping works to be completed by February 22. The team are working closely with colleagues in IPC to mitigate risks to patients in ward block 2 from exposure to dust particles. All external windows facing the demolition site will be sealed shut and air purifiers will be installed in ward 12 due to the patient group.

2.1.2 Community
Work to rationalise the estate footprint adjacent to HRI is now coming to an end. The disposal of 62 Acre Street is the last identified disposal. Lawyers have been appointed and the sale is due to complete this calendar year. The transaction is with Assura who are working with the GP Partners and CCG to develop a new GP practice on the site, after securing the Glen Acre House Car Park site last year.

2.1.3 LED Scheme
The LED scheme continues to progress at HRI albeit with challenges around timescales and delivery. The HRI programme has commenced. However, now with CV-19 delays the programme is currently around 85% complete and is already saving both energy and money

2.1.4 Fire Safety
Fire safety remains an area of focus at HRI. A recently completed fire audit by Mott MacDonalds has been reviewed and a capital plan of £400k has been approved. CHS are working alongside the Trust fire officer and the Fire Committee to prioritise the action plan following the audit and to commence design to roll out the capital plan.
The actions are around, community fire door remediation, HRI 30 min compartmentation, fire plans and signage. Architects have been appointed to create a package of fire compartmentation drawings for HRI and Community estate. A lift survey has also taken place looking at the suitability of existing lifts on the HRI site for fire evacuation purposes. The outcome of this survey is due shortly.

2.1.5 Portland Stone
The Portland stone cladding panels and windows remain a short and long-term risk at HRI. On-going maintenance and remediation continues to address the immediate risk. CHS estates are undertaking a process of due diligence to resolve the longer-term solution / replacement. This option includes over cladding the existing façade.

A feasibility study has been completed by our PSCP and a gross maximum price for the over cladding is being reviewed. The principal of over-cladding has not been agreed between the local authority building control and an independent approved inspector. The capital team are currently looking at other solutions and the impact to ward areas for internal works when removing the timber window frames. It is envisaged there will be a significant impact to the programme with 12-14 weeks required per ward and additional risk due to asbestos surveys of heating pipes below windows and structural suitability of low-level walls below windows, which cannot be determined without a full survey.

Risk Mitigation: To mitigate the risk of falling stone panels a 6-month survey is conducted by structural engineers BWB to assess the condition and movement. The latest survey was completed in June with only 1 stone found to have moved. This is in a low-risk area and we have appointed a contractor to make good and secure the stone back to the fabric of the building.

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

2.1.7 Ventilation
During the pandemic there has been a focus on ventilation air change rates across health care premises in the management of aerosol generating procedures (AGPs). The resulting work is to ascertain the air change rate per hour (ACH) for every area where patient care may take place across the Trust to assist the Trust in decision making. This work is now complete for HRI. A paper exploring the mitigations and subsequent advice was presented and approved by IMT in February. A number of air purifiers have been purchased and rolled out to a number of areas with approval from IPC colleagues.

2.1.8 ED Development
The new ED scheme is currently awaiting a planning decision, which is due in early September. The GMP (Gross maximum price) from IHP is due on the 20th of August. Design workshops have taken place over the last few weeks with key stakeholders, and comments fed back to the design team. Enabling works have commenced including the relocation of staff from Saville Court and the removal of meters, diversions of underground services etc have all been commissioned. The demolition of Saville Court is due to take place (planning decision permitting) in December/January following the completion of the nurses residence/learning centre demolition. Again, the capital team are working closely with IPC to mitigate risk and seal windows and install air purifiers to ward areas on Block 1. There is a significant impact to ‘access’ and we are working closely with stakeholders and communications to ensure all staff are made aware, and any solutions are put in place to not impact on the service.

2.2. Medical Engineering & Decontamination Service

2.2.1 Surgical Instrument Set Review and Loan Process
Having trialled an instrument loan process to minimise the time an instrument set is on loan to reduce daily costs, which was carried out at the CRH site. This is planned to roll out to the HRI site as well. Engagement has already begun with BBraun Contracts Manager who will engage with BBraun. This is combined with a review of instrument loans to scope the usage and potential to minimise costs by purchasing any sets that are routinely hired in. This is

combined with Theatre planned activity increase and where usage dictates may also present cost savings/avoidance.

2.2.2 Asset Tracking
Asset tracking to enable wards/departments to better manage their assets, favourites have been set up as a quick link to ward assets. As we have completed the audit, we will be adding each ward/departments assets to these favourites by grouping them into ward/department favourites.

2.2.3 Active Temperature Monitoring
Medical Engineering are in the process of reconfiguring the tags be redeployed to Pharmacy freezers. Ambient temperature tags have been deployed around the Trust into medicines storage areas this has identified areas of concern as over 50% were out of range. This has been communicated to CHS Estates @HRI and Equinix @CRH for them to investigate and potentially mitigate the areas where temperatures are routinely high. Pharmacy have also been informed so that they can scope the impact on medicine stored in those areas. The refrigerator tags are working well. The planned upgrade is due shortly. We are waiting for the upgrade to the temperature monitoring system before the SOP and "Go Live" date is agreed.

2.2.4 Training Development
Medical Engineering Training team continue to develop alternative training resources and methods of training delivery in order to adapt to the ever-changing situation, essential to keep up with demand and expand the Digital Training Catalogue. The training team have also been engaging with departments to scope needs and amendments that users are requesting. We are also reviewing the database system to see if it can be integrated to eQuip.

2.2.5 Training Compliance
CHS training compliance for Medical Devices remains above 95% and setting the standard for the Trust to follow, but we are looking to increase compliance in areas where this has dropped off.

Division	June	July
Surgical	65%	66%
Medicine	59%	60%
FSS	80%	79%
Community	74%	76%
Corporate	59%	69%
CHS	96%	95%
Trust	72%	74%

2.2.6 Scoping space for Medical Engineering
We are looking to gain space for Medical Engineering at HRI to accommodate the new staff and improve workflow and throughput. This has now taken on another aspect of reviewing the future service requirement at CRH as we look to reconfiguration and the potential needs for the staffing and space requirement to double.

2.2.7 Contract Management
This is now an agenda item at the Medical Device Procurement & Management Group (MDPMG) monthly meetings. The monthly review with Divisional Finance colleagues in order to agree the required variations has proven to be a workable solution.

2.2.8 Decontamination and Repair of Mattresses
"In house" decontamination and repair process, is now in full flow with Facilities Team to deliver the decontamination element and Medical Engineering to deliver the repair element of the service. While there were some service capacity issues to start with, due to a pump failure at Elland, this was promptly rectified and added resilience built into the water system. Staff have been recruited and are now trained on the in-service mattresses, but to assist existing Medical Engineering staff have been cross trained and will be receiving additional training over the coming months to support this service. We have instituted twice weekly meetings with Tissue Viability Service, Medical Engineering and Facilities Equipment lead to review current position. There has been added pressure with an unexpected rise in demand for pressure mattresses, where between 90 - 95% of asset are in use at any one time, which has meant that we have had to closely monitor throughput for decontamination and repairs to ensure they are expedited and availability is maintained.

2.2.9 KPI compliance
We have not been able to maintain compliance for all high-risk devices, which have dropped from Green to Amber. We only failed to meet the target by 0.54%. However, we expect to be able to regain compliance in the coming months. Medium and low risk devices remain Amber. This has been impacted by lack of staff over the latter part of the month due to covid isolation and essential maintainer training, which will enable staff to maintain assets.

2.2.10 Vacancy
In the coming month the following post will be advertised:
- Grade B Apprentice Administrative Assistant.
- Grade H Decontamination Manager.

2.2.11 Student Placements
We are planning to interview 3 new placements mid-August to begin in mid to late September.

2.2.12 Bank/Flexible Workforce
We are looking into starting a pool of bank/flexible workforce staff to support the services by utilising the placements after they have completed their training with us. It will add resilience to the service and offer potential for further development and possible future employment.

2.2.13 Replacement of Patient Monitoring
The replacement program is ongoing with an expected finish date in mid – late September. Monitors are already in place on HDU and due to be installed in recovery at CRH mid-August.

2.2.14 ESCRIBE/Dose Error Reduction Software (DERS)
Having engaged with Bradford we have shared our drug library with them to facilitate the rapid roll out in ICU at Bradford. There is potential for Bradford to utilise the existing infra structure to begin hardwiring their monitors before us as they already have access to the software, which was included with the purchase of their infusion pumps, which we are due to replace shortly.

2.2.15 Variations in Progress
Variations in preparation phase are:
- New non-medical equipment service, which will also include future in-house development of Medical Engineering Service to deliver its own services to community locations for both medical and non-medical equipment.
- IQ Air – air purifiers: A request has been received to maintain and change the filters on these assets. Scoping of costs and time required is underway.

- Recording of PPE training and reports, initial scoping, previous variation was submitted but not supported as a fixed term post was given to the Trust to carry out this task. However, that post has now been vacated as the staff member moved on and was not filled due to the need to recruit and the time remaining on the fixed term. Currently we are being asked to complete this task which is time consuming.

2.3. Facilities

2.3.1 Covid Support

Facilities services have been able to step down some of the additional services, which we have been providing over the past 12 months. However, have recently been asked to provide additional portering support on the 6.00am-2.00pm.

2.3.2 Laundry Tender

The laundry tender process is now complete and issued on Monday 2 August, with requests for providers to look at a pack to ward option and delivery/collection to/from both sites, rather than just HRI.

2.3.3 Retail catering

Retail project on track and moving forward at a fast pace. Programme of works is being looked at and handover timescales agreed. Equipment identified and ordered. Uniforms, tills, menus, rotas etc are all in progress and the project in where it should be. Compass are being accommodating and working with CHS to ensure everything goes smoothly.

2.3.4 Enhanced shuttle service

As part of the work to enhance and improve the shuttle bus service as identified in the Travel Plan developed for reconfiguration, additional stop off / pick up points were introduced on Monday 26th July.

These were in West Vale and Elland and the shuttle bus timetable has been updated to reflect the changes.

There are further plans to introduce a park and ride service in the autumn from Broad Street Plaza to CRH.

2.3.5 CIMS

The cleaning services department was reassessed for CIMS (Cleaning Industry Management standard) on 28 July and have been awarded accreditation with honours. A lot of hard work has gone into preparing for the assessment so a big thanks to the management team for their hard work and dedication.

2.3.6 National Cleaning Standards

New NHS Cleaning Standards have been launched with a 12-month implementation period. A meeting with the Trust has now taken place to establish who will be involved in implementation. Estates and ward colleagues are included in the group. Work is progressing slowly as the lead for the Trust is due to retire and to date no-one else has been identified to take their place.

2.4. Procurement

2.4.1 Materials Management

The team are continuing to provide PPE services, undertaking daily stock counts (to be reported nationally) and distribution of Lateral Flow tests with reduced numbers of staff especially at HRI. There have been several absences running concurrently during the month and include short term back issues, self-isolation due to Covid in the family setting, one positive Covid case and planned annual leave. It has been incredibly challenging and will remain so during the month of August. PDRs have been completed for those staff who booked dates in July/early August.

NHSSC / WYATT:

- Urine meters were moved over to Clinisupplies releasing a £2.8k saving.
- More meetings have taken place with Elemental Healthcare regards their sustainable offer and meetings schedule with the incumbent to discuss their sustainable offer.
- Challenges with supply and availability around blood admin sets due to international availability have meant a quick change to an alternative under the clinical approval of anaesthetics.
- Pipeline projects this month are sterile instruments and endoscopy consumables.
- WYAAT agreements for review include needle free devices, continence and iodophor dressings.

Scan4Safety:

- Catalogue work from the materials management side was completed on time for the end of July deadline.
- Board approval of recruitment of extra staff to support the inventory management implementation.

2.4.2 Category Management

The team are continuing to support their category areas and focus on contracts that were extended or rolled forward during COVID. BAU activity is very busy as is the activity on major projects such as Reconfiguration and Radiology MES. The team are working together to review current procurement processes and standardisation of workflows and documents to enable them to procure smarter, whilst evidencing value for money. The maintenance and leasing records are fully up to date and annual CIP savings have been identified through the renewals and extensions.

The Board approval of the implementation of the DHSC procured e-commercial end to end procurement solution has been great news this month. Atamis is a fully integrated, cloud-based and modular procurement solution supporting the entire strategic sourcing cycle. It empowers users to analyse and understand spending behaviour, plan procurement pipelines, complete e-tenders efficiently and manage contracts and the risk and performance of key suppliers. Using Atamis, CHS procurement will take large steps to becoming a proficient and compliant function, enabling us to drive efficiencies and deliver value for money for CHS and the Trust focussing on the key areas of the procurement cycle.

2.4.3 Operational Procurement

The team are currently working as part of the catering project, specifically looking at the till system, card machines, cash collection and the retail items for the outlets. We are working on a prescription eyewear project with stakeholders from the Trust to put in place a contract which will enable staff to receive prescription eyewear to allow them to conduct their duties safely and with the correct PPE. The team have been supporting on the Reconfiguration project and will be involved in the procurement workstream to deliver the procurement activity for the Reconfiguration programme. We continue to participate in housekeeping exercises to reduce unnecessary accruals prior to financial month end close-down. The Scan4Safety project continues to progress, we are currently finalising a review of catalogue data for wave 1

suppliers in collaboration with LTH in preparation for the roll out of the Inventory Management Solution.

3.0 CHS

3.1. Spotlight Awards

Moira retired at the end of July and during the 28 years of service she has shown loyalty, commitment and dedication to patient feeding. Moira worked in the catering department at HRI and began work in 1993 with Work Link (which was a work placed programme that catered for adults with learning disabilities) first at St Luke's Hospital until its closure. Over these years she became a constant in the department and around the hospital with never a bad word for anybody. The staff will miss her as she seemed to be the glue that kept the catering team all together. Moira has said on many occasions, that if over winter we need help if covid does rise, to give her a call and she will be back to help.

Mark and Kieran, portering chargehands were nominated for the July Spotlight Award by Chan Dhaliwal because when the service faced unprecedented sickness on a night shift, at short notice both Mark and Kieran showed great teamwork and flexibility in covering the shifts, with Kieran coming into work at 2.00am to support the service. Chan said they have both shown great commitment to the service and are a credit to the team.

3.2. Finance

3.2.1 Month 4 - July 2021

The month 4 position reports a £0.07m surplus against a plan of £0.07m with a nil variance. This position results from the over recovery of income (£1.06m) due to an increase in the goods and services being transacted through the company offset by an overspend on pay (£0.01m) (adverse to plan) and non-pay (£1.06m) (adverse to plan). Pay is overspent by £0.01m due to additional staffing being employed to carry out additional services requested by CHFT. Non pay is overspent by £1.06m due to an increase in goods and services being transacted through the company. Total income is above plan by £1.06m which reflects the increase in income invoiced for goods and services requested by CHFT.

3.2.2 Year To Date

The month 4 YTD position reports a £0.32m surplus against a plan of £0.29m with a £0.03m favourable variance. This position results from the over recovery of income £5.65 (favourable to plan) due to an increase in the goods and services being transacted through the company offset by an overspend on non- pay £5.57m (adverse to plan). Pay is £0.03m overspent (adverse to plan) due to additional staffing resources required to deliver services in response to COVID 19. This is offset by vacancies in senior positions and through funded variations agreed with CHFT Non pay is overspent by £5.57m due to an increase in goods and services

being transacted through the company. Total income is above plan by £5.65m which reflects the increase in income invoiced for goods and services requested by CHFT.

3.2.3 Forecast 2021/22
At this stage of the financial year there are no indications that the financial plan of £880k surplus will not be achieved.

3.2.4 Capital 2021/22
The month 4 position reports a £487k underspend to plan in main due to the deferment of the Learning Centre development to Autumn of this year (£375k). The year-end position is forecast to be within plan.

3.2.5 CIP 2021/22 Estates and Facilities
The target for CHS is £650k. At this stage schemes of £269k have been identified as recurrent relating to energy and waste and are at GW2 a further £216K are at GW1 leaving a £165k unidentified gap. Managers and heads of service are currently working on CIP plans to deliver the target in conjunction with CHFT.

3.2.6 CIP 2021/22 Procurement
The target for CHS is £750k. At this stage schemes of £28k have been identified as recurrent relating to NHS Supply Chain and maintenance contracts and are at GW2. The full year effect of these is forecast to be £152k leaving a shortfall of £598k. In order to address this gap CHS have secured additional funding of £100k from CHFT on an invest to save basis. This funding will be used to employ additional staff focusing on CIP delivery.

3.3. Workforce

3.3.1 Attendance
CHS Sickness rate for July is 6.7% comprising LTS 4.9% and STS 1.7% with stress and anxiety accounting for a quarter of all absences. Musculo-skeletal problems account for 20% of illness followed by chest and respiratory at 14%. This is an overall increase in absence from 5.7% last month.

Long term sickness (over 28 days) is a significant issue currently however there is a management plan with HR support, in place for each case.

3.3.2 Appraisal and Essential Skills Training
Appraisal season will run between July and October. CHS appraisal paperwork is being modified to include objectives for line managers and guidance on how to have a conversation with colleagues that more robustly supports succession planning and talent spotting. CHS Values and behaviours are reinforced in the paperwork, together with the Company objectives for the next 12 months.
Mandatory training remains in the blue domain at 95% + across all areas.

3.3.3 Life Assurance/Death in Service Benefit
Communications has been sent to all CHS staff on local terms and conditions to advise of the introduction of the above benefit. There is a portal for staff to access further information and hard copy information is available, including a beneficiary form to complete.

3.3.4 Customer Service/Values and Behaviours Training

The above face to face training has been developed and is being delivered weekly across the company in response to staff survey feedback that our staff are not always treated with respect by other colleagues. Whilst only small numbers are allowed in the sessions, due to covid restrictions, these have been well received and will roll out over the next 12 months, with on-line team sessions being available further down the line.

3.3.5 Retail Services – TUPE Transfer of Staff
Consultation meetings have taken place with Compass staff in relation to the TUPE transfer of retail services to CHS on 1 November 2021.
Unions are fully briefed on the matter and will support Compass staff though the process.
Structures and training needs are currently being considered and employee liability information has now been received.

4.0 KPIs

CHS provide 60 KPIs to CHFT of which just 5 **did not** achieve Green Target.

- **General Office** – All medical certificates and appointments booked with registrar within 5 working days – **RED NO**
- **Porters** – Immediate requests – **AMBER – 85.63%**
- **Medical Engineering –** High Risk PPMS – **AMBER - 79.46%**
- **Medical Engineering -** Medium Risk PPMS – **AMBER – 60.14%**
- **Medical Engineering -** Low Risk PPMS – **AMBER – 57.56%**

5.0 Risks

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

The very high / high risks that CHS seek to manage and mitigate are:
- HRI Estates failing to meet minimum condition due to age and condition of the building (20)
- Resus – Collective risk to maintain compliance / upgrade (20)
- ICU – Collective risk to maintain compliance / upgrade (20)
- Medical Engineering - There is a risk of equipment failure from Medical Devices on the current trust asset list (20)
- Fire safety due to breaches in compartmentation, and a lack of compartmentation in some areas, and enough staff trained in fire safety awareness and as fire wardens (in CHFT) (15)
- The façade of HRI (15).

6.0 Recommendation

Shareholders are asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – August 2021

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	4	0
Red Risks High	2	0
Amber Risks Moderate	27	0
Green Risks Low	11	0
Total	44	0

Risk ref + score	Strategic Objective	Risk	Executive Lead	Mar 21	April 21	May 21	June 21	July 21	Aug 21
CHS Risk 6903 (CHFT 7444 (12)	Keeping the base safe	Resus – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7271 (CHFT 7442 (12)	Keeping the base safe	ICU – Collective risk to maintain compliance / upgrade	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 5806	Keeping the base safe	Overall condition of the building –There is a risk to areas due to the age, environment and condition of the HRI building.	Managing Director (SS) General Manager Estates (CD)	=20	=20	=20	=20	=20	=20
CHS Risk 7438 (CHFT 7474 (15)	Keeping the base safe	There is a risk of equipment failure from Medical Devices on the current trust asset list of 19,456 Medical Devices due to a very large number (n=5359) of High Risk devices (n=837), Medium and Low Risk devices which are out of service date and have not been seen for extended periods of time.	Manager Director (SS) Head of Medical Engineering (RR)	=20	=20	=20	=20	=20	=20
CHS Risk 7318 (CHFT 7414 (15)	Keeping the base safe	There is a risk to life and building due to the failed / heavily corroded metal ties that hold back the Portland Stone cladding at HRI, particularly Ward Black 1 South Elevation potentially resulting in falling Stone debris.	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15
CHS Risk 5511 (CHFT 7413 (15)	Keeping the base safe	Collective Fire Risk – There is a risk of increased fire spread and delayed evacuation at HRI	Managing Director (SS) General Manager Estates (CD)	=15	=15	=15	=15	=15	=15

The Risk Register has been noted by CHS Board

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

- Finance and Performance Committee meetings held 01.06.21 & 28.06.21
- Quality Committee meetings held 21.06.21 & 19.07.21
- Audit and Risk Committee - 21.07.21
- Council of Governors Minutes – 15.07.21
- Annual General Meeting (AGM) Minutes – 28.07.21
- Workforce Committee meetings held 09.08.21

APP A

DRAFT Minutes of the Finance & Performance Committee held on Tuesday 01 June 2021, 10.00am – 12.00pm Via Microsoft Teams

PRESENT

Helen Barker	Chief Operating Officer
Gary Boothby	Director of Finance
Richard Hopkin	Non-Executive Director (CHAIR)

IN ATTENDANCE

Andrea McCourt	Company Secretary
Peter Keogh	Assistant Director of Performance
Philip Lewer	Chair
Rhianna Lomas	PA to Director of Finance (Minutes)
Stephen Baines	Governor Representative

ITEM

081/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

082/21 **APOLOGIES FOR ABSENCE**

Apologies were received from Anna Basford, Owen Williams, Peter Wilkinson, Kirsty Archer and Stuart Baron.

083/21 **DECLARATIONS OF INTEREST**

There were no declarations of interest to note.

084/21 **MINUTES OF THE MEETING HELD 5 MAY 2021**

The Minutes of the Public meeting held 5 May 2021 were **APPROVED** as an accurate record subject to the following amendment being made:

- The Chief Operating Officers action regarding discussing short and long term sickness with the Director of Workforce should be removed. This has been addressed in separate discussions between the Chair and Director of Workforce.

085/21 **ACTION LOG AND MATTERS ARISING**

The Action Log was reviewed as follows:

069/21: Financial Risks 2021/22: The Director of Finance agreed to investigate whether the risk register narrative for H2 had been amended as requested at the previous meeting.

069/21: Recovery Coordination & Oversight Group Terms of Reference: The Terms of reference (TORs) were received by the Committee. It was understood that the group is established and operating. The Director of Finance highlighted that a paper will be submitted to WEB this Thursday regarding an investment proposal. This is evidence that correct governance and processes

are in place/being followed. The Committee **APPROVED** the TORs. **Action Closed.**

FINANCE & PERFORMANCE

086/21 **MONTH 1, FINANCE REPORT INCLUDING HIGH LEVEL RISKS & EFFICIENCY PERFORMANCE**

The Director of Finance highlighted the key points reported at Month 1:

- The papers received were abbreviated this month due to year end pressures.
- In Month 1, the Trust delivered a surplus of £0.62m, a favourable variance of £0.55m compared to plan.
- A pressure has been seen due to higher staffing levels in the segregated Emergency Department (ED) and Critical Care. However, this is offset by the underspend on planned developments.
- Additional income from the recovery fund has not been assumed however, based on Month 1, CHFT would be entitled to £0.86m. This relies on the overall ICS performance which as yet is not confirmed.
- Underperformance has been noted against CIP therefore work will be done to resolve this in Month 2. It was noted that being above the activity target indicates efficiency and this should be clarified and labelled as CIP.
- Agency spend has exceeded the trajectory at Month 1. Conversations are being held with the divisions to understand the cause. Spend was particularly high in Medicine therefore at the recent Performance Review Meeting (PRM) forecasting was a focus.
- It was understood that the levels of overperformance will diminish throughout H1.

The risks were not included within the pack and will therefore be circulated outside of the meeting.

ACTION: To circulate the financial risks to the Committee **– GB, 28/06/21**

The Chief Operating Officer expressed the need for a system response regarding how urgent care is handled financially. It was noted that this is currently being discussed as a system challenge. Agency spend had been higher within ED as it was not able to introduce the new model by April 1st, 2021 as planned due to new Covid variants. Plans are being revised and funding will be required. The Director of Finance noted that the Covid reserve could be utilised. All agreed to keep monitoring the situation.

The Chair requested an audit update to which it was noted that a close down meeting had been held in which no concerns were flagged. KPMG have also reported an improvement to the Trust's value for money (VFM) position. Minor testing is ongoing however a positive internal audit response has been received.

The Committee **NOTED** the Month 1 finance report.

087/21 **INTEGRATED PERFORMANCE REVIEW – APRIL 2021**

The Chief Operating Officer reported that the Trust's performance for April 2021 was 69.3%. The following key points were highlighted:

- The IPR has been updated. Feedback is required from this Committee before it is finalised.
- Deterioration has been seen in April due to the finance and responsive domains. From a responsive perspective the deterioration relates to cancer screening and Day 38. Work is ongoing regarding the screening piece with Mid Yorkshire. (It was noted that CHFT are purely a host site for the Bowel Cancer patients.)
- ED is extremely busy, and this volume cannot be safely managed without expanding the footprint on a formal basis. The high volumes are a system wide issue therefore a proposition will be available ready for the next Committee meeting as the daily piece of work that was being conducted ends this week. The plan will displace the orthopaedic outpatients; therefore, system responsibility is required to agree how this is re-provided. It was noted that a modular outpatients may be needed.
- The team continue to monitor the Inpatient P values at Specialty level concentrating on P2s > 30 days, P3s > 3 months and 104 week waits. They are looking at the nuances in each specialty as they are not necessarily choosing the correct patients and in addition there appear to be more P2s being created and we need to understand why this is happening. Below is a summary that was explained of a recent 7 week period showing how numbers are changing over time. Note that P2s are showing no real change which is mainly due to more additions in certain specialties.

Total	P1	Small numbers	-40.0%	100.0%
	P2	No real change	-2.5%	100.0%
	P2 > 30 days	Decreasing	-16.7%	100.0%
	P3	Decreasing	-2.7%	100.0%
	P3 > 3 Months	Decreasing	-10.0%	100.0%
	P4	No real change	-0.8%	100.0%
	P5	Decreasing	-48.8%	100.0%
	P6	Increasing	133.3%	100.0%
	104 weeks	Increasing	114.3%	100.0%

- In Ophthalmology an alarming trend has been seen in the variation between Black, Asian and minority ethnic (BAME) and non BAME patients. A deep dive is being done regarding this that relates to the current contract. BAME is being monitored weekly but will not be included within the IPR.
- Endoscopy is a concern due to an increase in fast track diagnostic patients causing the six week patients to wait longer. A cross check is being carried out against the cancer pathway to ensure priority is being given correctly.
- 66% of patients on the waiting list with a learning disability have had treatment and this will increase to 76% by the end of this month. CHFT are supporting Locala with their disability capacity however the Trust's 104 week wait position is deteriorating as there are now 30 on that list

relating to a range of specialities. There is an increasing number on the bariatric waiting list therefore a conversation will be held regarding whether these patients should be prioritised.
- The Chief Operating Officer delivered a presentation to the Committee regarding stroke. Sentinel Stroke National Audit Programme (SSNAP) data for July 2020 was shown which noted that CHFT had a few reds and ambers. The October-December 2020 position was given an overall B rating, despite having some Cs. The April 2021 position looks improved and the Assistant Director of Performance will be assessing this data to predict whether it will be graded as an A or B. Due to this, the deadline for the stroke action can remain in October 2021.
- Slides were also shown regarding waiting lists. It was understood that a high volume of the activity carried out does not count towards the Trust's referral to treatment (RTT) position. As outpatient attendances increase, the waiting list does also therefore more patients are currently being added to the list than leaving it.
- CHFTs second submission aimed for higher activity levels than the first (93% to 107%) however this remains realistic. A meeting was held with York and Rotherham hospitals to learn how they are planning to deliver their proposals.
- The Trust is continuing to prioritise cancer.
- The WYAAT waiting list data shows that CHFT has the second highest volume of patients over 52 weeks. However, it has one of the lowest P2 waiting lists. Work is being done with ENT, TNO and General Surgery alongside Mid Yorks and Bradford to understand the difference in numbers.
- The Chief Operating Officer has spoken with NHSEI to seek an opinion on the current levels so that any necessary changes can be made sooner rather than later.

It was agreed to circulate the presentation given by the Chief Operating Officer.

ACTION: To circulate the supplementary data presentation **– HB, 28/06/21**

Lead Governor, Stephen Baines, noted the current struggle to gain an appointment with a doctor and questioned whether this is having an impact on the high volume of patients in ED. The Chief Operating Officer explained that it is GP dependent as some have found that they can still gain access however there is evidence of patients that have had a telephone/virtual appointment being directed to ED for scans. As part of the national Covid response GPs were directed to close their electronic booking systems and this is ongoing therefore phonelines are busier. An evening surge is being seen in ED due to most GPs closing at 6pm. Therefore, a plan is required as the Chief Operating Officer is still unsure whether this is the new norm.

The Chair noted that he is looking forward to seeing the outcome of the review that will measure CHFT against other hospitals, feedback will be given regarding this at the next meeting. The ED footprint decision will also be discussed next month. It was requested that all Committee members feedback regarding the updated IPR to the Chief Operating Officer/Assistant Director of Performance outside of the meeting. The Chair liked the updated IPR and appreciated the focus on quality indicators/controls and the Strengths,

Weaknesses, Opportunities and Threats (SWOT) analysis. It was noted that the SWOT is not a replacement for the performance narrative.

The Director of Finance explained that if the Trust were to deliver the revised activity level, it would be entitled to £4.8m funding and this would increase the overall fund to £8m. The bids regarding additional activity will be assessed at this week's WEB.

Triangulation reports will be produced for Trust Board meetings in order to deliver further performance information and link it to workforce, quality, and finance. It was agreed to share the updated IPR with all Non-Executive Directors in order to gain their feedback.

ACTION: To circulate the updated IPR to all Non-Executive Directors in order to gain feedback **– PK/HB, 28/06/21**

The Committee **NOTED** the IPR for April 2021.

088/21 **FISCALLY UNIQUE**

The Director of Finance delivered the updated Fiscally Unique presentation that was last discussed two years ago.

- It was noted that the presentation acts as evidence towards the Trusts Use of Resources (UoR) assessment.
- In 2018 the planned deficit was £43m, whereas in May 2021 the planned deficit is £24.4m.
- In March 2019, CHFTs income had improved compared to 2018. Our private finance initiative (PFI) drove a £7-£10m challenge.
- The reconfiguration business case identifies £10m worth of opportunities due to the reconfiguration.
- In 2018 the Trust flagged as an outlier due to higher levels of borrowing/depreciation plus higher costs for Clinical Negligence Scheme for Trusts (CNST.)
- In March 2019 it was concluded that despite having the Health Informatics Service (THIS) and Huddersfield Pharmacy Specials (HPS) as contributing sectors, this did not make CHFT unique as other Trusts also have contributors.

The presentation then focussed on changes and updates to the last assessment:

- Since 2018 a new finance regime has been introduced. This converted the Trust's debt into public dividend capital meaning it no longer pays interest rates plus changes to the regime and funding through Finance Recovery Fund has allowed CHFT to deliver a balanced financial position on a control total basis.
- The Trust still has an expensive estate. Model Hospital calculates the cost per Weighted Activity Unit (WAU), and this is focused on how CHFT compares with other Trust's. This data shows that the Trust's estate cost per WAU is high at 739 compared to the average of 525. This gap grows every year due to the inbuilt inflation within the PFI contract being higher than the inflation built in to Trust funding.

- Estates operating costs are higher at CRH than HRI and the conclusion was that using the PFI is £13m more expensive than a non PFI model would be.
- The Trust has higher than average CNST costs. Whilst these have dropped, we remain an outlier due to CHFTs costs remaining at £3.5m more than the average for other similar organisations. We are fiscally unique due to this and there is nothing that can be done to improve the situation in the short term.
- The Trust remains an outlier on depreciation. St Luke's, Acre House and the Poplars were sold however the Trust remains an outlier. Some of this is due to CHFTs digital maturity and the investments into THIS and HPS.
- Overall, the Trust runs a £26m/£27m difference. This presentation identifies that there are some elements out of CHFTs control and concludes that CHFT cannot eliminate the deficit in the short term.

The Chief Operating Officer expressed a view that some Trusts have different arrangements with the CCGs regarding the Yorkshire Ambulance Service (YAS) and RTT therefore the Trust should explore this.

The Director of Finance explained that decisions had been made regarding transport to support the Trust that in other organisations, CCGs may have funded. Work is ongoing with commissioners to understand this position across West Yorkshire.

The higher depreciation due to THIS capital investments (e.g. EPR) was challenged and argued that this investment brought savings and positive contribution. It was recognised that there had been a challenge in understanding how the quality improvements triangulate financially. The Chair noted that a paper was produced that evaluated the investment made and this showed a positive financial outcome therefore we should be seeing the proposed benefits. The Director of Finance accepted this challenge.

It was questioned whether the adverse movement on the PFI premium will continue to grow and secondly, whether the costs are built into the reconfiguration project. It was described that this is dependent on Project Echo. If it is progressed, then it will carry on into year 40 of the contract therefore CHFT are attempting to put a fix on the increase. Work is also being done to evaluate the future of the Trust's soft and hard facilities management contracts. In the short term, the gap will widen, however, it may improve due to Project Echo which will bring with it re-negotiations. The Director of Finance noted that the PFI brings capital and revenue challenges and this has been seen recently with the MR Scanner.

It was suggested that the estate/digital piece be used to inform the working from home strategy currently being developed as an investment in digital technology would mean less people on site which equals less need for estate. However, the Director of Finance expressed a financial concern that, due to Covid, investment has been made to allow colleagues to work from home however due to social distancing the released space is being used by other colleagues instead, therefore creating no clear benefits.

The Committee **NOTED** the Fiscally Unique presentation.

089/21 **USE OF RESOURCES**

The Chair introduced the item by explaining that an update was required based on the "requires improvement" rating given in 2018. It was previously suggested that an external review be conducted but this has not been possible. Therefore, himself and Non-Executive Director, Peter Wilkinson, have been involved to review the draft document. The document circulated demonstrates that CHFT has made good progress since 2018. The Director of Finance highlighted the following points to the Committee:

- The scope detailed on page three had been agreed at this Committee, which is to summarise the current position, remind all of the actions, collate evidence, create a repository and identify potential opportunities.
- The Trust has had a balanced financial position over the last two years and KPMG have reported that CHFT an improved VFM position.
- The evidence held in the review room on Convene will be combined into one PDF so that it is available to issue to the assessors when necessary.
- The UoR system is highly mathematical and some of the work the Trust does (that is right to do) does not improve the metrics. This fact has been discussed with the regulators.
- The document demonstrates good engagement from clinical teams as within the pack, there are slides that were presented and delivered by them.
- The further opportunities category creates a challenge. A new approach regarding efficiencies will be agreed within the coming months.
- It was understood that there are data issues with the most recent Model Hospital data. All non-elective activity has been accounted for as non elective short stay. This has made CHFT appear as the most expensive hospital in the country. Model Hospital have refused to update the data however Manchester and Wigan are in the same position. The Trusts will therefore lobby as a group to change this. The Director of Finance will update the Committee as soon as possible.

The Company Secretary noted that Use of Resources is on the Board Assurance Framework as a risk and therefore questioned whether this is correct going forward. The Director of Finance agreed to update the narrative however he does not intend to take this report to the Board. The Chair noted that it will be mentioned within his highlight report and it can be shared with any other Board member that requests it.

The Committee **NOTED** the Use of Resources paper.

GOVERNANCE

090/21 **REVIEW SELF ASSESSMENT ACTION PLAN**

The self-assessment action plan was received by the Committee. The Director of Finance noted good progress had already been made against a number of

the actions. It was agreed to review the action plan again before the conclusion of the calendar year.

ACTION: To review the self-assessment action plan before the conclusion of the calendar year **– RH, 29/11/21**

The Assistant Director of Performance noted that the IPR can no longer be issued prior to WEB. The action plan will be amended in order to reflect this.

ACTION: To amend the action regarding the issuing of the IPR to reflect that it will be circulated post approval at WEB **– RL, 28/06/21**

The Committee **NOTED** and **APPROVED** the Self-Assessment Action Plan subject to the agreed amendments being included.

091/21 DRAFT MINUTES FROM SUB-COMMITTEES

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

- A&E Delivery Board held 13 April 2021
- Commercial Investment & Strategy Committee held 22 April 2021
- HPS Board held 10 May 2021
- Capital Planning Group held 13 May 2021

It was understood that the summary sheet for the A&E Delivery Board would be circulated after the meeting once available.

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

092/21 WORKPLAN - 2021/22

The updated Work Plan was **NOTED** and **APPROVED** by the Committee.

093/21 MATTERS TO CASCADE TO BOARD

The Chair will produce a summary report to be submitted to Board. This will highlight the approval of the Recovery Coordination and Oversight Group TORs, the Month 1 Financial Performance, the updated IPR (including April outcome), the Fiscally Unique presentation and the Use of Resources paper.

094/21 REVIEW OF MEETING

The Chair noted that the meeting had concluded within two hours and all items had been successfully discussed.

095/21 ANY OTHER BUSINESS

There was no further business to discuss.

DATE AND TIME OF NEXT MEETING:

Monday 28 June 2021, 11:00 – 13:00, Microsoft Teams

APP A

DRAFT Minutes of the Finance & Performance Committee held on Monday 28 June 2021, 11.00am – 13.00pm Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Kirsty Archer	Deputy Director of Finance
Mandy Griffin	Managing Director – Digital Health (Item 101/21)
Peter Keogh	Assistant Director of Performance
Rhianna Lomas	PA to Director of Finance (Minutes)
Stuart Baron	Associate Director of Finance

ITEM

096/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed attendees to the meeting.

097/21 **APOLOGIES FOR ABSENCE**

Apologies were received from Helen Barker and Stephen Baines.

098/21 **DECLARATIONS OF INTEREST**

Declarations of interest were noted for Stuart Baron as a Director of CHS.

099/21 **MINUTES OF THE MEETING HELD 1 JUNE 2021**

The Minutes of the meeting held 1 June 2021 were **APPROVED** as an accurate record.

100/21 **ACTION LOG AND MATTERS ARISING**

The Action Log was reviewed as follows:

125/20: IPR, Outcome Based Indicators – The indicators are included within the IPR quarterly however the Assistant Director of Performance will liaise with the Chief Operating Officer to identify a deep dive date.

149/20: Stroke Deep Dive & Outpatient Update – The Chair will discuss with the Chief Operating Officer whether both updates will be received in one meeting or alternatively spread over two.

069/21: H2 Financial Plan – The finance team are still awaiting the briefing that will provide further guidance. Until then a plan cannot be produced.

069/21: Risk Narrative – The Deputy Director of Finance confirmed that the amendment had been made. **Action closed.**

086/21: Circulate Month 1 Financial Risks – Included within the Month 2 papers circulated to the Committee. **Action closed.**

087/21: Circulate updated IPR to Non-Executive Directors – It was confirmed that the IPR had been circulated. **Action closed.**

090/21: Amend Self-Assessment Action Plan – An amended self-assessment action plan has been circulated to the Committee. **Action closed.**

FINANCE & PERFORMANCE

101/21 **DIGITAL STRATEGY**

The Managing Director of Digital Health informed the Committee that the Digital Strategy was received at Weekly Executive Board last week and will be submitted to this week's Trust Board. The following key areas were discussed, and achievements were highlighted.

Covid19 Pandemic/Recovery: Mobilisation of the workforce enabled 2000 colleagues to work from home. Business intelligence provided data on health inequalities and disability. This information has been produced regularly and will aid recovery. Software has been developed to help with the recovery/reducing the backlogs as colleagues were able to assess clinical need. The rollout of NPEX nationally was a success, within months 160 labs were connected.

Interoperability: Great progress has been made using the Health Information Exchange software. Adult Social Care is now connected to CHFTs EPR. Since the report, a Mental Health Trust has also been connected. THIS are working alongside Kirklees Council at their Digital Board to see if they can also be connected.

Integration: There are three main areas of focus; the Pharmacy system, Ophthalmology system and Maternity system.

Projects and programmes: £4.6m was spent in 2020/21 on capital investment. The majority was funded by Digital Aspirant funding and Scan 4 Safety. THIS worked alongside finance colleagues to ensure the funding was spent and delivered within the fiscal year despite the pandemic. Multiple projects supported Covid for example the ability to provide virtual visiting and virtual consultations. £4.2m investment has been identified for 2021/22 and business cases are being created.

Governance: Processes are well embedded due to Digital Boards being in place. There is an aim to improve the accuracy of the resource requirements detailed within the business cases produced.

Infrastructure: Commissioned UK Cloud, they are producing a strategy and business case that will be available by the end of July and submitted to Board

where a decision will be made. HIMMS Accreditation is in place and across all EMRAM models THIS score between four and five. Looking to be awarded stage six by the Autumn of 2021.

Optimisation: Due to Covid there has been a delay in working on this with frontline colleagues, work will begin soon. Working with the place and the ICS. Leading the way on Scan 4 Safety. Regarding asset tracking nearly 3,000 devices have been tagged. Work is also going well regarding LIMS.

Digital inclusion: Work is ongoing connecting people, patients, and relatives. Much has been achieved however the EQIA (Equality Impact Assessment) within the report details further requirements.

The Committee were invited to ask questions. Non-Executive Director, Peter Wilkinson noted that the data produced regarding health inequalities is impressive. He proceeded to enquire whether THIS benchmark themselves against other Trusts/private sector organisations regarding digital performance, investment and KPIs. It was understood that there are various ways the organisation is benchmarked. The digital maturity index is produced regularly across the NHS and CHFT are within the upper quartile on this. Model Hospital also benchmarks however this is mainly based on cost. The Managing Director agreed to provide the Digital Maturity Assessment for Peter Wilkinson and include it within the Board report.

ACTION: To circulate the Digital Maturity Assessment to Non-Executive Director, Peter Wilkinson **– MG, 02/08/21**

The Director of Finance noted that spend is higher however this is not surprising due to the advancement when compared with other Trusts. The Chief Executive emphasised that the HIMMS assessment is the main reflection of an organisation's digital standard and CHFT is at a high level on this. The Trusts no paper approach reduces human error and good work has been done regarding blood tracking and milk tracing. Only six trusts in the UK are HIMMS accredited level six/seven and CHFT are nearing level six. The Trust is used as a best practice example at multiple Boards. The aim for the new Managing Director will be to improve the functionality and capability across Community systems like Systm1 the systems used by Locala).

It was understood that work is ongoing to assess the first round of benefits in the Commercial Investment & Strategy Committee. The Managing Director was pleased to note that the Trust was 9th on the list for imaging collaborative however CHFT became the first to implement. The Chair summarised the achievements and felt assured by seeing the work on interoperability as it will link with the efficiency engagement work that is ongoing. Overall, the summary reflects good progress, and this should be celebrated.

102/21 **INTEGRATED PERFORMANCE REVIEW – MAY 2021**

The Assistant Director of Performance reported that the Trust's performance for May 2021 was 71.1%. The following key points were highlighted:

- The hard truths section has been reworked and placed back into the pack. There are new graphs regarding quality priorities.
- The overall score has decreased slightly. There are three green domains. Finance and Workforce are close to being green. The main challenge is Responsive as this encompasses ED, Cancer, and the Recovery Programme.
- 100% compliant regarding complaints being closed within the deadline. This has improved due to deadlines now being agreed with the family.
- There is no national guidance on the friends and family thresholds therefore internal targets have been set. All areas are green apart from Maternity which is being assessed. This has helped to improve the caring position.
- Dementia screening remains a challenge. A new Dementia Lead is joining the Trust soon and an improvement should be seen.
- The Responsive area did deteriorate regarding Stroke again. Only one of the targets was achieved however a CT scanner was not available for part of the month and there were some medical outliers which made the standards hard to achieve. On a weekly basis improvement is being seen.
- There has been a small deterioration in 28 day cancer diagnosis, however overall cancer performance continues to be excellent.
- The ED has seen a notable increase in the number of attendances; however not all are converting into admissions. The complexity of the patients attending has increased also, this data will be shared.
- Regarding Workforce, there has been a slight decrease on returning to work however this has not impacted the bottom line score.
- The agency expenditure has no ceiling and an ambitious plan was set internally therefore a slight deterioration has been seen.
- A detailed triangulation narrative has been created in which positives have been included to recognise the great work being done around recovery. Good progress has also been seen regarding treating patients with learning disabilities. Since the HSJ article CHFT have received interest from other organisations and are therefore delivering presentations to them. The volume of heath inequalities data should also be celebrated.
- The vacancies and skill mix require a review.
- Community are noting complex presentations. Cancer referrals are being dealt with however volumes are rising.
- There has been a further increase in SHMI, and work is being done regarding out of hospital deaths.
- The deputies will continue to meet monthly to create a strong narrative for the Board and Non-Executive Directors.

The Chair noted that the narrative is helpful. All were made aware that the April score was amended after the previous Committee meeting therefore categorising May as a deterioration.

Non-Executive Director, Peter Wilkinson questioned why complaints had improved and whether long term sickness was related to specific areas. It was noted that complaints have improved due to agreeing thresholds and timescales with families, however a 100% score will not be seen every month.

Regarding long term sickness, Workforce are aware of ten hotspot areas within the organisation. Work is being done with those areas to improve this. In general, sickness figures are good. The Chair has discussed this topic with the Director of Workforce, and it was agreed to conduct a deep dive into absence to be seen at the Workforce Committee prior to this Committee.

Regarding recovery, the graphs indicate that good progress is being made on P2 patients however CHFT are behind the trajectory therefore there is still some work to do. The Director of Finance highlighted that the system has been meeting two to three times a week to find a solution for the high volumes in ED and a proposed model has been created for October onwards with Local Care Direct. This would cost an extra £2m per year. On Friday a proposal was agreed costing £100k for the next three months to increase Emergency Nurse Practitioners and to increase the scope of patients seen by Local Care Direct out of hours. The CCGs are working on this. The age detail of patients is available and there are ongoing investigations regarding who is attending and why. Recovery is not going at the planned pace therefore each speciality has been assessed in detail and each have nuances. The targets will be re-worked amongst the specialities to ensure they are realistic. The ED could not be de-segregated as planned. A revised staffing model for nurses has been reviewed today which details a higher than budgeted spend however this is lower than the current spend. All agreed that the organisation has to ensure it has the correct level of staff to cope with the additional demand.

103/21 **POST COVID-19 RE-SET / BUSINESS BETTER THAN USUAL**

The Assistant Director of Performance gave a detailed and informative presentation to the Committee based on the slide pack within the papers circulated prior to the meeting.

It was questioned which of the twenty projects shown related to recovery will produce the greatest benefits. The Clinical Reference Group was highlighted as a success due to the involvement it gains from clinicians. The deep dive by speciality will help us to understand the situation further. The health inequalities/BAME data has also been useful.

The Chief Executive queried whether the intent to transfer to Any Qualified Provider (AQP) is ethically legitimate and questioned where CHFT will access these given the footprint does not have any existing designated providers. The Assistant Director of Performance agreed to discuss this with the Chief Operating Officer. The distinction between Limited Liability Partnership (LLP) and AQP was clarified.

The Director of Finance noted that CHFT will continue to commission further independent sector activity. The Trust has robust data and good reporting that allows the organisation to be confident in its own data.

The Chief Executive expressed a concern that the Committee need more clarity on the position in order to truly understand it. The Assistant Director of Performance explained that completing additional activity (with funding thresholds achieved) and reducing the waiting lists are separate goals. It was noted that the waiting list is likely to continue to grow.

It was agreed to ensure the narrative is made clear next time it is presented. It was agreed to gain a further update on recovery at this Committee.

ACTION: To provide a further update regarding the recovery position to the Committee **– PK/HB, 02/08/21**

104/21 **MONTH 2, FINANCE REPORT INCLUDING HIGH LEVEL RISKS & EFFICIENCY PERFORMANCE**

The Director of Finance highlighted the key points reported at Month 2:

- Year to date the Trust has delivered a surplus of £3.28m, a favourable variance of £2.94m compared to plan.
- This favourable variance is mainly driven by higher than planned Elective Recovery Funding (ERF). It was noted that the funding is easier to achieve in the earlier months and the thresholds will keep increasing. The recovery costs have been lower than planned and vacancies have also aided the favourable variance.
- The Covid costs have not decreased in accordance with the plan as the costs to ensure the ED is segregated continue and high attendance volumes in the ED have created a higher than planned agency expenditure.
- The forecast for H1 is a breakeven position, the plan is cautious however it links with the approach taken by the ICS to assume a break even.
- The plan has been resubmitted in the last week due to a request from NHSI to incorporate the elective recovery funding into the plan. The decision has been made to assume a £4.3m fund offset by £4.3m costs.
- The presentation of CIP within the paper will be reworked to ensure clarity and full context. Information regarding activity will be simplified and compared with 2019/20.
- The cash and Better Payment Practice Code position remain positive.

The Chair questioned how agency expenditure is being managed. The Director of Finance explained that the situation is being monitored. There are not enough theatre staff due to a combination of vacancies and also insufficient numbers willing to partake in extra sessions due to pandemic fatigue. The Trust has been approached to suggest increasing pay rates for agency staff. Work is taking place across WY to check consistency and ensure the line is being held. Controls around the pay rate remain in place. It was agreed to review the controls that are in place.

ACTION: To review the controls in place regarding agency staffing across the Trust **– OW/GB, 02/08/21**

Robust agency forecasts will be produced. The Data Quality Board review the agency staffing position and it has been noted as positive. A deep dive is currently underway regarding this and the results will be helpful. It was highlighted that the impact of any agency decisions need to be assessed.

High level risks: The H1 plan score is 8 and this may seem high however it is based on not knowing how ERF will affect the plan.

105/21 **BOARD ASSURANCE FRAMEWORK**

Changes to the BAF have been flagged in red and scores have been amended. Six risks are overseen by this Committee. There are three operational risks that relate to keeping the base safe and three regarding financial sustainability.

The Chair questioned whether Risk 7/19 should sit with the Quality Committee. It was understood that Risk 7/19 has been adapted to ensure that the CQC element falls into Risk 4/20 owned by the Executive Director of Nursing.
The Chief Executive suggested that a risk be created to encompass the increased threat of claims and litigation from delays in patient care. This will be discussed with the Company Secretary outside of the meeting. Risk 05/20 has been decreased from a score of 20 to 16. The Chair suggested that this be kept under review as the backlog position is not improving as quickly as anticipated. It was highlighted that the score will continue to be refreshed as the position is monitored.

The Committee approved the BAF and it was agreed to review it quarterly.

GOVERNANCE

106/21 **DRAFT MINUTES FROM SUB-COMMITTEES**

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

- CHFT/THIS Contract Review meeting held 20 April 2021
- THIS Executive Board held 28 April 2021
- A&E Delivery Board held 11 May 2021
- THIS Executive Board held 26 May 2021
- Capital Planning Group held 15 June 2021

The Chair noted that the THIS minutes detailed a potential issue regarding data protection ESR compliance. The Managing Director explained that this standard is required in order to be HIMMS level 6 compliant, therefore work is ongoing to lift the percentage to 95%. If this is not met in the short term, the compliance status will be altered once it is achieved, although the goal is to avoid any delays.

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

107/21 **WORKPLAN - 2021/22**

The updated Work Plan was **NOTED** and **APPROVED** by the Committee.

The Director of Finance explained that the HPS Commercial Strategy will be seen at HPS Board in time for submission to the Finance & Performance Committee meeting taking place 2 August 2021.

108/21 **MATTERS TO CASCADE TO BOARD**

Will be covered within the Chairs highlight report to the Board.

109/21 **REVIEW OF MEETING**

The Chief Executive expressed that it had been a thoughtful meeting. The Chair agreed that valuable discussions had taken place.

110/21 **ANY OTHER BUSINESS**

There was no further business to discuss.

DATE AND TIME OF NEXT MEETING:

Monday 2 August 2021, 11:00 – 13:00, Microsoft Teams

QUALITY COMMITTEE

Monday, 21 June 2021

STANDING ITEMS

96/21 WELCOME AND INTRODUCTIONS

Present

Name	Role
Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Christine Mills **(CM)**	Public-elected Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Name	Role
Vanessa Dickinson **(VD)**	Head Nurse – Medical Division **(item 102/21)**
Judy Harker **(JH)**	Lead Nurse – Tissue Viability **(item 102/21)**
Philip Lewer **(PL)**	Chairman **(Observing)**
Paula McDonagh **(PMc)**	Sepsis Nurse **(item 102/21)**
Dr Rob Moisey **(RM)**	Consultant - Acute Medicine **(item 102/21)**
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Jean Robinson **(JR)**	Senior Infection Control Nurse **(item 100/21)**
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs
Shelley Watson **(SW)**	Interim Senior Risk Manager **(item 101/21)**
Jonathan Wood **(JW)**	Specialist Nurse – Gastroenterology **(item 102/21)**

97/21 APOLOGIES

Name	Role
Dr David Birkenhead **(DB)**	Medical Director
Andrea McCourt **(AMcC)**	Company Secretary
Elisabeth Street **(ES)**	Clinical Director of Pharmacy

98/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

99/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 24 May 2021 were approved as a correct record. The action log can be found at the end of these minutes.

SAFE

100/21 INFECTION CONTROL ANNUAL REPORT

Jean Robinson presented appendix D, providing the key points as noted in the report, and also providing the flu vaccination and COVID-19 staff compliance rates of 80% and 78.5% respectively.

The Quality Committee acknowledged the efforts and phenomenal work from the Infection Prevention and Control (IPC) team over the last 18 months and asked that thanks are conveyed to all. JR stated that it has been an extraordinary year and also wanted to thank the

organisation for supporting and working with the IPC team to get through the last 12-18 months.

OUTCOME: JR was thanked for the update and the Committee noted the report.

101/21 HIGH LEVEL RISK REGISTER

Shelley Watson presented appendix E, which covered the period of 7 April to 1 June 2021.

Since the last report, two new risks were added to the high-level risk register: risk 8029 - open maternity pathway, and 7479 - caring for young people with acute mental health issues. Ten existing risks remain and may stay on the high-level risk register for some time, and two risks have been removed: risk 7778 – staff becoming infected with COVID-19, and risk 7936 – social distancing (staff behaviours). One risk has been reduced in score; risk 7981 – reduced senior cover in both Emergency Departments.

The Chair asked if there were any further updates on risks 7454 – radiology staffing risk, and risk 8021 – Theatre capacity for emergency obstetrics. SW stated that further updates are expected for both risks at the next Risk Group on Wednesday, 4 August 2021, and that the registers are monitored on a regular basis with support provided to divisions with the management of their risks.

A copy of the full high-level risk register was also provided.

OUTCOME: The Committee received and noted the report.

RESPONSIVE

102/21 TRUST QUALITY REPORT

Doriann Bailey presented appendix C, providing the key points as noted in the report. In relation to the maternity report, it was asked whether the Trust's response to Ockenden will come to the Quality Committee, and it was confirmed that that the Committee will receive the minutes from the Perinatal Quality Surveillance meetings.

Presentations were provided this month by operational leads for four priorities, one from a quality account priority, and three on the focused quality priorities:

- *Recognition and timely treatment of sepsis* - Dr Rob Moisey and Paula McDonagh provided an update on the three measures for the quality account priority for sepsis. CP stated that this quality priority will also feed into the newly formed Care of the Acutely Ill Patient (CAIP) Programme, the first meeting of which will be taking place next week. SW noted that the risk in relation to sepsis recognition and treatment not currently being part of the essential safety training should be added to the risk register, which was agreed. RM and PMcD were thanked for the update.
- *Nutrition and Hydration for inpatient adult and paediatric patients* – Vanessa Dickinson and Jonathan Wood provided an update on the 15 measures for the focused quality priority for nutrition and hydration. EA commented that a clinical lead for the nutrition and hydration group is required, as well as a renewed focus on nutrition being an integral part of a patient's wellbeing and treatment plan. With regard to automatic referral to the dietetics service, LW asked if there will be any capacity in the service if there was an increase in demand. JW stated that the team are aware of the potential for increase into their workload, and VD stated that an audit will be done on the number of referrals, and a period of monitoring will be carried out. With regard to the training compliance increase, LW asked if there was any rationale as to why the completion of the Malnutrition Universal Screening Tool (MUST) was not taking place. It was stated that this is something which will be looked into as part of the 'back to basics', in order to identify any constraints within the ward environments and routines. VD and JW were thanked for their update.

- *Reduction in the number of CHFT acquired pressure ulcers* – Judy Harker provided an update on the 10 measures for the focused quality priority for pressure ulcers. JH was thanked for the update.
- *Making complaints count* – Rachel White provided an update on the eight measures from the national regulations and Parliamentary and Health Service Ombudsman (PHSO) standards. Reasonable assurance is being seen across all the standards in which the key priorities are being focused. RW was thanked for the update.

OUTCOME: The Committee received and noted the report.

CARING

103/21 ANNUAL COMPLAINTS REPORT

Rachel White asked for the Committee to approve the report, at appendix F, in order for submission to the Board of Directors in September 2021.

RW noted that there has been an increase in Patient Advice and Liaison Service (PALS) contacts and concerns, and a decrease in complaints, however, this is likely due to public consideration during the pandemic. The greatest concerns relate to appointments and overall performance in relation to complaints has increased, with the top three complaint issues relating to clinical treatment, the fundamentals of care and communication. The complaints team were acknowledged for their hard work and continued attention to complaints, and also to the sharing and learning process.

Action: Any feedback on the Annual Complaints report to be forwarded to RW by Monday, 28 June 2021. The report will be submitted for approval at the next Quality Committee meeting.

104/21 PATIENT AND CARERS EXPERIENCE, PARTICIPATION AND EQUALITIES STRATEGY 2020-2025

Rachel White presented appendix G, providing the context and background to the development of the strategy, and noted that there is still some work to be done before submission to the Board of Directors.

Action: Any feedback on the strategy to be forwarded to RW by Monday, 28 June 2021. The final strategy will be submitted for approval at the next Quality Committee meeting.

105/21 MECHANISMS FOR THE SYSTEMIC INVOLVEMENT OF OUR BAME COMMUNITIES

Rachel White presented appendix H, which should be read in conjunction with the strategy at item 104/21, which focuses on the involvement of the Black, Asian and Minority Ethnic (BAME) communities.

Action: Any feedback on the mechanism to be forwarded to RW by Monday, 28 June 2021. The final mechanism will be submitted for approval at the next Quality Committee meeting.

106/21 COMMITMENT TO CARERS

Rachel White presented appendix I, recognising that carers should form part of the caring group whilst patients are being looked after. There was careful consideration in relation to visiting during the pandemic, and as a Trust, recognise carers as an integral protected characteristic group. Further work is needed within the Trust in relation to commitment to carers, to become aligned with other partners within the West Yorkshire and Harrogate Partnership.

It was proposed that a collaborative with a shared responsibility is formed to adopt a pragmatic approach in order to move this forward, and the Quality Committee were asked to endorse a collaborative to focus on key clinical areas for engagement.

OUTCOME: The Committee were supportive of the approach and endorsed the proposal.

107/21 IMPACT STORIES: LEARNING FROM INSIGHT

Rachel White presented appendix J, which sets out a process agreed by the Patient Experience and Caring Group, to develop robust learning from complaints, incidents, experience and other insight, to be taken forward in the Trust. This will enable the Trust to articulate the impact made from the work, being visible from ward to Board, and also to the public.

A reporting schedule has been set out and work is ongoing with the Community division to assist translating their endeavours into an impact story. The Quality Committee were asked to endorse this approach and to see the results of impact stories from ward to Board.

OUTCOME: The Committee were supportive of the approach and endorsed the approach.

108/21 EVERY STORY MATTERS

Rachel White presented appendix K, which is an ambition to develop a robust process for sharing stories and to be assured that organisational learning will take place. It was noted that these are not complaints, incidents or enquiries, but personal stories to be taken forward in order for the organisation to learn from them. The Quality Committee were asked to endorse this process, and EA asked for a formal review in a few months to ensure that it is manageable.

The Chair asked how this will be communicated across the divisions, and RW agreed to attend any meetings to raise the profile further if necessary. Discussion to take place outside of the meeting in relation to involving divisions.

EFFECTIVE

109/21 LEARNING FROM DEATHS ANNUAL REPORT

Dr Cornelle Parker presented appendix L, providing a review of mortality during 2020-2021, and highlighting key points from the report. CP also mentioned, which was not included in the report, that it has been discovered that the Trust's same day emergency care activity is being incorporated into Hospital Episode Statistics (HES) submissions going back several years when it should not have. This is currently being analysed to identify what impact this would have, if those measures are not included, as our same day emergency care activity has been increasing significantly over the last few years. It is not known what bearing this will have on our mortality metrics.

The Committee were asked to approve the annual report and the recommendations of:

- Supporting the additional actions scrutinising Standardised Hospital Mortality Index (SHMI) described in the report, including the establishment of the Care of the Acutely Ill Patient (CAIP) quality improvement programme
- Supporting the requirement of the Medical Examiners' Office to review deaths within the community. The scrutiny of community deaths will begin by the end of quarter 3, aiming to be at 50% capacity by the end of quarter 4 (2021/22)
- A target of 50% of all in-patient deaths to be subject to Initial Screening Review by June 2022. Deaths in Elderly and Respiratory specialities account for half of inpatient adult deaths. The Mortality Surveillance Group (MSG) have asked the mortality leads and clinical directors for these areas to develop a plan of action to address the deficit in reviews for 2020/21

OUTCOME: The Committee approved the annual report and the recommendations.

RESPONSIVE

110/21 2020-2021 QUALITY ACCOUNT

The Chair reported that a decision has been made for an extraordinary meeting to be convened to formally approve the 2020-2021 quality account, which is a delegated responsibility from the Board of Directors to the Quality Committee.

The Chair asked that Committee members attend the meeting on Wednesday, 23 June at 3:00 pm to sign-off the Quality Account.

111/21 INTEGRATED PERFORMANCE REPORT

Ellen Armistead asked that the Committee note the report at appendix N.

OUTCOME: The Committee noted the report.

WELL-LED

112/21 BOARD ASSURANCE FRAMEWORK

The Board Assurance Framework at appendix O was provided for information.

POST MEETING REVIEW

113/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- The Trust Quality Report, with the first progress reports against the key performance indicators for one quality account priority, and three focused quality priorities
- The Infection Prevention and Control Annual Report and the excellent work of the team over the last year. This report will also be submitted to the next Board of Directors.
- The suite of reports from patient experience
- The Learning from Deaths Annual Report

114/21 REVIEW OF MEETING

Committee starting to receive regular reports on quality priorities.

115/21 ANY OTHER BUSINESS

The Chair noted that this will be Christine Mills' last meeting, at the moment, as Governor to the Committee, and wished to convey thanks for being a great member of the Committee.

ITEMS TO RECEIVE AND NOTE

116/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix P for information.

NEXT MEETING

Monday, 19 July 2021 at 3:00 – 5:00 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 21 JUNE 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS / ACTIONS DUE FOR NEXT MEETING				
21.06.21 (103/21)	**Annual Complaints Report**	Rachel White	**Action 21.6.21**: Any comments / feedback on the Annual Complaints report to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting.	**Due July 2021**
21.06.21 (104/21)	**Patient and Carers Experience, Participation and Equalities Strategy**	Rachel White	**Action 21.6.21**: Any comments / feedback on the Strategy to be forwarded to Rachel by Monday, 28 June 2021. The final strategy will be submitted for approval at the next Quality Committee meeting.	**Due July 2021**
21.06.21 (104/21)	**Mechanisms for the systematic involvement of our BAME communities**	Rachel White	**Action 21.6.21**: Any comments / feedback on the involvement of our BAME communities' presentation to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting.	**Due July 2021**
21.06.21 (108/21)	**Every Story Matters**	Rachel White	**Action 21.6.21**: Any comments / feedback on Every Story Matters framework to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting.	**Due July 2021**
21.06.21 (110/21)	**Quality Account**	All	**Action 21.6.21**: An extraordinary meeting to be convened for Wednesday, 23 June 2021, to sign-off the document which the Committee has been delegated authority from the Board of Directors.	**Due July 2021**
24.05.21 (90/21)	**IPR – Safer Programme**	Hannah Wood	DS also noted the challenges with increased numbers of patients coming through the ED and issues with the delayed transfer of care. EA stated that there needs to be more systems conversations in relation to the delayed transfers of care, as well as non-complex discharges. Throughout COVID-19, there were a set of 'must-do' actions which are now being reviewed, and one needs to be around patient flow, well-organised discharge and having plans in place over the weekend. There are still some improvements to be made internally about fundamental organisation of care. LR suggested that it would be useful for the presentation on the Safer Programme to come into the Committee. **Action**: Hannah Wood to be invited to the next Quality Committee to present the Safer Programme. **Update**: SAFER has had a launch meeting but not held its first board yet. A comprehensive update of the workstreams will be provided for the July meeting.	**Due July 2021**
24.05.21 (91/21)	**Quality Committee Sub-group terms of reference**	Michelle Augustine / Chair of Medical Gases and NIV Group	Medical Gases and Non-invasive Ventilation Group DS queried the quoracy of the group, as outlined in the terms of reference at appendix I, stating that the expectancy that core members attend 50% of the meetings is too low, and that attendance should be at least 75% as other Quality Committee sub-group terms of reference. **Action**: Terms of reference to be returned to the Medical Gases and Non-invasive Ventilation Group for amendment and resubmitted to the Quality Committee for ratification	**Due July 2021**
24.05.21 (90/21)	**IPR - Dementia Screening**	Lauren Green	DS noted no improvement in the dementia patient screening, which was either flatlining or deteriorating. EA reported that the new dementia nurse lead is now in post, with one of the workstreams which she will be leading on is dementia screening. Some of it is possibly the way in which it is being recorded, however, this is being looked into. **Action**: Lauren Green (Dementia Nurse Lead) to be invited to the Quality Committee.	**Due July 2021**
CLOSED ACTIONS				
No actions were closed in June				

App B - Quality Committee - 16.08.21

QUALITY COMMITTEE

Monday, 19 July 2021

STANDING ITEMS

122/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Christine Mills **(CM)**	Public-elected Governor
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Casey Atack **(CA)**	Student Midwife **(observing)**
Emma Catterall **(EC)**	Head of Complaints **(observing)**
Lauren Green **(LG)**	Dementia Lead Practitioner **(item 126/21)**
Karen Spencer **(KS)**	Associate Director of Nursing – FSS Division **(item 129/21)**
Janet Youd **(JY)**	Head of Nursing & Midwifery Workforce & Education **(item 128/21)**
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs

123/21 APOLOGIES

Dr David Birkenhead **(DB)**	Medical Director
Andrea Dauris **(AD)**	Associate Director of Nursing - Corporate
Lindsay Rudge **(LR)**	Deputy Director of Nursing

124/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

125/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 21 June 2021 were approved as a correct record, with the exception that Lauren Green's title on the action log is amended from Dementia Nurse Lead to Dementia Lead Practitioner.

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

126/21 MATTERS ARISING

Dementia Screening

Lauren Green was in attendance to present appendix O, providing an update on dementia screening.

It was noted that compliance overall compliance is currently at 27%, with a target of 95%. LG will be working with the medical workforce to improve dementia screening across the Trust, via induction and building it into the clerking process. This will be work in progress.

LG was thanked for the report and an update on progress was requested for a future meeting.

OUTCOME: The Quality Committee noted the report.

SAFER Programme

Action: To be deferred to the next meeting.

127/21 QUALITY COMMITTEE TERMS OF REFERENCE

A copy of the amended terms of reference were circulated at appendix C, highlighting the addition of the Cancer Board as a sub-group, with the minutes being received on a quarterly basis.

AD HOC REPORTS

128/21 LIGATURE POLICY

Janet Youd was in attendance to present the ligature policy at appendix P, which was created following the publication of a Patient Safety Alert in 2020 on ligature and ligature point risk assessment tools and policies.

JY noted that there were some challenges in obtaining rescue packs, however, they have now been ordered and due to be delivered on-site on 16 August 2021, and colleagues are to be made aware of where they are located. The functions of the policy were summarised, including the assessment and safety of patients; a standard operating procedure and processes of what to do if a patient is found to be ligatured, and what to do afterwards in terms of the wellbeing of colleagues; the estate, and training.

The appendices (ligature risk assessment and ligature point audit) are yet to be added to the Policy, which will be determined by the Mental Health Operational Group.

The Chair asked how soon the training can be accessible to colleagues. JY stated that this is yet to be added to the electronic staff record. It was also asked that an audit is carried out to ensure that colleagues who may have been involved in a ligature incident, received an appropriate level of support.

The Chair asked if there were any particular areas where priority training would need to take place. JY stated that areas which have had previous ligature incidents, such as the acute floor, the emergency department, the children's ward with CAMHS (child and adolescent mental health services) patients and ward 17 (gastroenterology), would be deemed as high-risk and would have the training rolled out initially, however, people could potentially ligature in any area.

JY was thanked for the presentation of the Policy.

OUTCOME: The Quality Committee noted and approved the Policy.

SAFE

129/21 MATERNITY REPORT

Karen Spencer was in attendance to present the maternity report at appendix D, briefly highlighting that since the last update, all evidence for the Ockenden review was submitted by the 30 June 2021 deadline, with the next step being a site visit to review the service against the submission. It is not known when this visit will take place.

CHFT were also successful in achieving funding for 10.9 wte (whole time equivalent) midwives and 0.2 wte Consultant hours. No confirmation has yet been received on when the funding will be released.

CHFT continue with roll-out plans for continuity of carer, however, workforce challenges remain one of the biggest barriers to the successful roll-out.

The maternity incentive scheme was suspended in April 2020 due to COVID-19, and was relaunched in October 2020, with a further revision of the standards in March 2021. CHFT will be reporting compliance with all 10 safety actions.

It was noted that although there is a national shortage of midwives, CHFT have 186 wte midwives, and can continue to provide services. The roll-out of continuity of carer, which is an NHS E/I priority will be challenging, due to the midwife hours and midwifery care required. It was asked if there is a national solution to try and encourage more midwives. KS stated that the shortage of midwives is reflected in the shortage of registered nurses. Huddersfield University, which is linked to CHFT for midwifery training, have a second cohort of trainees and have recently been approved to run a midwifery apprenticeship programme, which will be a route into midwifery.

In terms of any long-term national transformational work to review skill-mix and develop new roles, the Chair asked if there was any progress with this. KS stated that there is national work still to be done, with continuity of carer being the approach for midwifery.

EA asked about the increase in the stillbirths and how CHFT benchmark with other organisations. KS stated that anecdotally, there has been a rise in stillbirths during COVID-19, and early data suggests that the increase has not been from women who have not accessed care, however, this may be from women who smoke and those with health inequalities. It was asked that the results of this audit is submitted to the next Quality Committee.

OUTCOME: The Quality Committee noted the report.

CARING

130/21 PATIENT EXPERIENCE AND CARING GROUP REPORT

The report at appendix E was received by the Committee.

OUTCOME: The Quality Committee received and noted the report.

EFFECTIVE

131/21 JOHN SMITH STADIUM COMMUNITY VACCINATION CENTRE

Elisabeth Street provided an update on appendix F, highlighting that the last vaccinations are due to take place at the end of August 2021, with a view to being decommissioned in the next few weeks. The next steps include supporting the booster vaccination campaign, and a plan to set up two smaller hubs (one in North Kirklees and one in Greater Huddersfield) to administer 1,500 – 3,000 doses per week. It is likely that Locala will lead on this. One of the complications was communication, with CHFT having overall governance, Curo as lead operational provider, and Locala and local care direct providing clinical support. Moving to a different model with Locala delivering and leading on the work will be a positive. It is not yet clear what CHFT involvement / responsibility will be if Locala complete the CQC registration of the two new sites. This is being awaited.

EA was not confident that the paper fulfilled its purpose to assure the Committee that effective systems of internal control are in place. Due to the complicated governance arrangement in terms of CHFT being lead provider and the agreed route that the Quality Committee would have oversight of quality and governance concerns, it was requested that a retrospective, detailed report of the incidents is provided, given that one of the providers was recently rated as inadequate by the CQC.

Action: A final quality assurance paper to be resubmitted to the Quality Committee.

WELL-LED

132/21 CQC AND COMPLIANCE GROUP REPORT

Ellen Armistead presented appendix G highlighting the closure of three 'should do' actions as detailed in the report. CQC engagement meetings continue to take place and the last meeting reviewed the Trust recovery plans.

Our internal assurance mechanisms include the journey to outstanding reviews, with a pilot completed and full launch to commence in July 2021. It is uncertain what the next phase will be for the journey to outstanding reviews due to staffing issues.

CHFT are not compliant with standards 9 and 10 of the facing the future standards. The organisation is to ensure that risk mitigations are in place and being monitored monthly.

OUTCOME: The Quality Committee received and noted the report.

133/21 QUALITY COMMITTEE'S SELF-ASSESSMENT RESULTS

The Chair thanked the Committee for their responses to the annual self-assessment, with the results available at appendix H.

Overall, whilst there was general agreement on many of the responses, there were also a number of 'strongly disagree', 'disagree' or 'unable to answer' responses. It was proposed that a review of last year's action plan takes place in light of this year's assessment to see where progress has been made, and it was also suggested that any feedback or comments from the Committee on this year's results, would be valued. These would form part of the Quality Committee's annual report.

Action: Any comments on the responses from the self-assessment to be sent to Denise Sterling by Monday, 26 July 2021

RESPONSIVE

134/21 INTEGRATED PERFORMANCE REPORT

Ellen Armistead briefly presented appendix I, highlighting that 100% of complaints were closed within time, and noted a deterioration in stroke, cancer and fractured neck of femur, however, the response for stroke give a description of the problem, and does not provide a response. It was suggested that someone from the Stroke team is invited to the Committee to discuss those issues.

Action: Dr P Rana to be invited to attend the Quality Committee to describe issues within Stroke.

Stroke	Stroke - Only 1 out of 4 targets achieved in the month. % Stroke patients spending 90% of their stay on a stroke unit has decreased in month to 84.91% compared with 89.83% the previous month. This remains below the 90% target. % Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival was 49.06% which is a decrease from 61.02% the previous month. % Stroke patients Thrombolysed within 1 hour was 83.33% which above the 55.56% seen during April and remains above target. % Stroke patients scanned within 1 hour of hospital arrival was 36.84% compared with 59.2% in April.	Of the 26 patients who were admitted into the Stroke bed base more than 4 hours after their arrival at hospital, 8 of these were due to there being no bed availability on the Stroke unit due to medical outliers in the Stroke bed base. One of the CT scanners at CRH was out of operation for some time during May which impacted on both timeliness of patient scans and subsequent time of admission into the Stroke bed base. This impact is currently being quantified. The stroke assessment bed continues to be operational in the ED 24/7 however there have been significant challenges in staffing this overnight with consultant cover. This is required to be classified as a stroke assessment bed. The team is continuing to ensure the integrity of data and all identified breaches are now being validated clinically to ensure against any data errors before being reported.	Sustainable recovery of SSNAP A standard for Stroke services. Accountable: Divisional Director Medicine/Dr Rana.

135/21 SUB-GROUP TERMS OF REFERENCE

Clinical Outcomes Group

A copy of the Clinical Outcomes Group terms of reference was provided at appendix J and approved by the Committee.

Medical Gases / Non-invasive Ventilation

A copy of the Medical Gases / Non-invasive Ventilation group terms of reference was provided at appendix K and approved by the Committee.

POST MEETING REVIEW

136/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- Approved the Ligature Policy
- Approved the Annual Complaints Report
- Approved the terms of reference for the Clinical Outcomes Group and the Medical Gases / Non-Invasive Ventilation (NIV) Group
- Received monthly maternity report with funding received and submitted evidence for Ockenden.
- Key points raised from the Integrated Performance Report
- Received the CQC and Compliance Report and the Patient Experience and Caring Group report.

137/21 REVIEW OF MEETING

Good time management of meeting.

138/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

139/21 CHFT QUALITY ACCOUNT 2020/2021

A final copy of the CHFT Quality Account for 2020/2021 was available at appendix L.

140/21 SPIRE QUALITY ACCOUNT 2020/2021

A copy of the Spire Healthcare Quality Account for 2020/2021 was available at appendix M.

141/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix N for information, and the review dates for the Board Assurance Framework (BAF) risks are to be scheduled over the next few months.

NEXT MEETING

Monday, 16 August 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 19 JULY 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
			OPEN ACTIONS / ACTIONS DUE FOR NEXT MEETING	
24.05.21 (90/21)	**IPR – Safer Programme**	**Hannah Wood**	DS also noted the challenges with increased numbers of patients coming through the ED and issues with the delayed transfer of care. EA stated that there needs to be more systems conversations in relation to the delayed transfers of care, as well as non-complex discharges. Throughout COVID-19, there were a set of 'must-do' actions which are now being reviewed, and one needs to be around patient flow, well-organised discharge and having plans in place over the weekend. There are still some improvements to be made internally about fundamental organisation of care. LR suggested that it would be useful for the presentation on the Safer Programme to come into the Committee. **Action**: Hannah Wood to be invited to the next Quality Committee to present the Safer Programme. **Update**: SAFER has had a launch meeting but not held its first board yet. A comprehensive update of the workstreams will be provided for the July meeting. **Action 19.7.21**: To be deferred to the next meeting	**Due 16 August 2021**
19.07.21 (131/21)	**John Smith Stadium Community Vaccination Centre Paper**	**Asifa Ali / Dr David Birkenhead**	Following presentation of the report, the Committee felt that the paper did not fulfil its purpose to assure that effective systems of internal control are in place. It was asked that a retrospective detailed closed-down quality assurance paper is provided. **Action 19.7.21**: That a final quality assurance paper is resubmitted to the Quality Committee.	**Due 16 August 2021**
19.07.21 (133/21)	**Quality Committee Self-Assessment Results**	**All**	The Chair presented the results from the Committee's self-assessment which took place in April 2021. Whilst there was general agreement on many of the responses, there were a number of questions which resulted in a 'Strongly Disagree', 'Disagree' or 'Unable to answer' response. The results will form part of the Quality Committee's Annual report, and any further feedback or comments on the areas with responses 'Strongly Disagree', 'Disagree' or 'Unable to answer' will be valued. **Action 19.7.21**: Any comments on the responses from the self-assessment to be sent to DS by Monday, 26 July 2021	**Due 26 July 2021**
19.07.21 (134/21)	**Integrated Performance Report - Stroke**	**Dr Pratap Rana**	Following presentation of the IPR, the Committee felt that the response for stroke does not provide a description of the issues and requested that a representative from the Stroke team attends the Quality Committee to discuss. **Action 19.7.21:** Dr P Rana is invited to attend the Quality Committee to describe issues within Stroke.	**Due 16 August 2021**
			CLOSED ACTIONS	
21.06.21 (103/21)	**Annual Complaints Report**		**Action 21.6.21**: Any comments / feedback on the Annual Complaints report to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting. **Update 19.7.21: The report was approved**	**CLOSED 19 July 2021**
21.06.21 (104/21)	**Patient and Carers Experience, Participation and Equalities Strategy**		**Action 21.6.21**: Any comments / feedback on the Strategy to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting. **Update 19.7.21: The strategy was approved**	**CLOSED 19 July 2021**
21.06.21 (104/21)	**Mechanisms for the systematic involvement of our BAME communities**		**Action 21.6.21**: Any comments / feedback on the involvement of our BAME communities' presentation to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting. **Update 19.7.21: The presentation was approved**	**CLOSED 19 July 2021**
21.06.21 (108/21)	**Every Story Matters**		**Action 21.6.21**: Any comments / feedback on Every Story Matters framework to be forwarded to Rachel by Monday, 28 June 2021. The final report will be submitted for approval at the next Quality Committee meeting. **Update 19.7.21: The framework was approved**	**CLOSED 19 July 2021**

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 19 JULY 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
21.06.21 (110/21)	**Quality Account**		**Action 21.6.21**: An extraordinary meeting to be convened for Wednesday, 23 June 2021, to sign-off the document which the Committee has been delegated authority from the Board of Directors. **Update 19.7.21: Following the extraordinary meeting, the CHFT Quality Accounts have now been approved and is available at item 139/21**	**CLOSED 19 July 2021**
24.05.21 (91/21)	**Quality Committee Sub-group terms of reference**		Medical Gases and Non-invasive Ventilation Group DS queried the quoracy of the group, as outlined in the terms of reference at appendix I, stating that the expectancy that core members attend 50% of the meetings is too low, and that attendance should be at least 75% as other Quality Committee sub-group terms of reference. **Action**: Terms of reference to be returned to the Medical Gases and Non-invasive Ventilation Group for amendment and resubmitted to the Quality Committee for ratification **Update 19.7.21: Terms of reference revised at available at item 135/21**	**CLOSED 19 July 2021**
24.05.21 (90/21)	**IPR - Dementia Screening**		DS noted no improvement in the dementia patient screening, which was either flatlining or deteriorating. EA reported that the new dementia nurse lead is now in post, with one of the workstreams which she will be leading on is dementia screening. Some of it is possibly the way in which it is being recorded, however, this is being looked into. **Action**: Lauren Green (Dementia Lead Practitioner) to be invited to the Quality Committee. **Update 19.7.21: LG presented an update at item 126/21**	**CLOSED 19 July 2021**

Draft Minutes of the Audit and Risk Committee Meeting held on Wednesday 21 July 2021 commencing at 10:00 am via Microsoft Teams

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

IN ATTENDANCE	
Andrea McCourt	Company Secretary
Gary Boothby	Director of Finance
Kirsty Archer	Deputy Director of Finance
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
Jenny Langdon	Assistant Manager, KPMG
Mandy Griffin	Managing Director, Digital Health
Jacqueline Ryden	Reconfiguration Programme Governance Lead (minutes)
Richard Hill	Head of Health and Safety **(for item 34/21)**
John Gledhill	Public Elected Governor – Lindley and the Valleys

48/21 APOLOGIES FOR ABSENCE

Apologies were received from Clare Partridge, Salma Younis, Leanne Sobratee and Amber Fox.

The Chair welcomed everyone to the Audit and Risk Committee meeting, in particular Jenny Langdon from KPMG, John Gledhill as a governor representative and Richard Hill, Head of Health and Safety who was in attendance to present a Health and Safety Deep Dive.

49/21 DECLARATIONS OF INTEREST

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

50/21 MINUTES OF THE EXTRA-ORDINARY MEETING HELD ON 10 JUNE 2021

The minutes of the extra-ordinary meeting held on 10 June 2021 to sign off the annual report and accounts 2020/21 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous extra-ordinary meeting held on 10 June 2021.

51/21 ACTION LOG AND MATTERS ARISING

The action log was reviewed, and all actions were complete.

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

52/21 HEALTH AND SAFETY DEEP DIVE

Richard Hill, Head of Health and Safety presented a health and safety deep dive highlighting the work that has been undertaken during the past 12 months. He reported that colleagues are showing a genuine interest and are engaged and that the Trust is

DRAFT

on track to develop and implement the NHS Workplace Health and Safety Standards by the end of 2021. Areas for development are focussing on improving the content of training for new starters, accident reporting and assurance that due diligence is in place around slips, trips and falls.

The key points to note in the presentation were:

- There are 7 major priorities for the Trust to focus on in order to keep the base safe. These are: Quadriga Recommendations; Dangerous Goods Safety Advisor (DGSA) Audit Recommendations; NHS Workplace Health and Safety Standards Implementation; Community Compliance Improvements; Improvements in Huddersfield Pharmacy Specials (HPS), Keeping the Base Covid Safe; Keeping a firm hold on the more frequent occurring accidents. The Head of Health and Safety gave an update on the progress made in each of these areas and what remains to be done.
- All Quadriga outstanding actions should be completed by January 2022; outstanding actions following the Dangerous Goods Safety Advisor audit should be completed by the end of August 2021.

RH noted that it was reassuring to see how much progress has been made and that the health and safety profile has increased. Following a query from RH regarding the progress made to date in Huddersfield Pharmacy Specials (HPS), the Head of Health and Safety advised that engagement from colleagues in this area has been excellent. A lot of gaps had been identified initially but he believed that HPS is now at 95% of where they need to be. The next stage will be to implement the policies and provide training, and that some more work on the risk register is required.

In response to a query from DS regarding incident reporting, the Head of Health and Safety explained that the Health and Safety NHS Group are trying to develop some benchmarking which could enable comparisons on Datix incident reporting levels.

The Chair asked if the Risk Policy referred to in the presentation was the overall Trust policy or a separate Health and Safety Policy. The Head of Health and Safety advised that he was referring to the overarching Health and Safety Policy which contained within it individual policies and a statement of intent by the Chief Executive. It is anticipated that this statement of intent will be shared with colleagues to raise awareness.

The Chair asked if the Trust is in good shape against the national standards and the Head of Health and Safety reported that the Trust is around 70% of where we need to be and is on track to meet the standards.

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

53/21 REVIEW OF COMMITTEE ANNUAL REPORTS

1. Audit and Risk Committee Annual Report 2020/21

The Company Secretary presented the annual report for 2020/21.

RH noted that there was some confusion in the years reported in section 2.2 and that 2020/2021 should also be included. The Company Secretary agreed to make the necessary amendments regarding consistency.
Action: AM to make the required amendments to the Audit and Risk Committee Annual Report 2020/21 and circulate to the Group.

The Chair pointed out that section 2.6 did not include any information regarding the Data Quality Board and that he has asked the Company Secretary to add some wording in this section. He has also asked that Committee attendance is included in the report, in line with the reports from the other committees.

Action: AM to make the add wording on data quality and Committee attendance to the Audit and Risk Committee Annual Report 2020/21 and circulate to the Group.

2. Finance and Performance Committee Annual Report 2020/21

The Company Secretary reported the annual report for the Finance and Performance Committee is attached for assurance which was approved by the Board of Directors on 1 July 2021.

3. Workforce Committee Annual Report 2020/21

The Company Secretary reported the annual report for the Workforce Committee is attached for assurance which was approved by the Board of Directors on 1 July 2021.

DS advised that the Annual Report 2020/21 for the Quality Committee will be presented at the next meeting of the Audit and Risk Committee in October 2021.

The Chair asked if it would be appropriate to receive an annual report for the Transformation Programme Board. JR advised that this was currently being developed with the intention to share at the Transformation Programme Board meeting in August and subsequently at the Private Trust Board meeting in September. AN confirmed that this route would provide sufficient assurance without the need to share at the Audit and Risk Committee.

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee Annual Report for 2020/21 subject to the amendments outlined above and **RECEIVED** the Annual Reports for 2020/21 for the Finance and Performance Committee and the Workforce Committee.

54/21 REVIEW OF TERMS OF REFERENCE

Audit and Risk Committee Terms of Reference

The Chair reported the Audit and Risk Committee terms of reference have recently been reviewed and are here for approval with changes highlighted in red.

RH pointed out two clarifications that were required in section 8.1 regarding the highlight reports and 8.2 regarding removing the word annually. The Company Secretary will clarify and update the Terms of Reference.

Action: AM to make the required amendments to the Audit and Risk Committee Terms of Reference and circulate to the Group.

OUTCOME: The Committee **APPROVED** the revised terms of reference for the Audit and Risk Committee subject to the above amendments.

55/21 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments

The Deputy Director of Finance presented a report summarising the losses and special payments in the final quarter. The key points to note were that there has been a slight increase in the quarterly value compared to the previous year, although there are always variations from quarter to quarter. There was a loss of £48k consisting of expired critical medicines that are required to be stocked which relates to a range of drugs across both sites.

DS asked if this increase in quarter 1 could be attributed to any particular cause and the Deputy Director of Finance speculated that it had been an unusual year due to the pandemic and that it would seem logical that this was the explanation, but she agreed to confirm this with the Pharmacy Department.

Action: KA to confirm with Pharmacy if the pandemic is the driver for the increase in stocks of critical medicines.

The Chair asked RH if HPS were satisfied with the controls and procedures in place and RH confirmed this to be the case. The Director of Finance added that certain products have to be held in case of urgent treatment needed and that a robust system is in place amongst pharmacists across West Yorkshire.

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

2. Review of Waiving of Standard Orders

The Deputy Director of Finance presented the quarter report showing a total of 11 during this quarter period at a total cost of £247,171.46 from 1st April 2021 to 30th June 2021. The themes mainly related to continued maintenance and licencing. It was noted that compared to the previous year there has been a significant drop-off in relation to Covid expenditure, reflective of the fact that the majority of (Personal Protective Equipment) PPE is now sourced from Central Supply through NHS supply routes with very few exceptions. The Director of Finance added that one item has been added for completeness but is not truly a waiver – Calderdale CCG wish to use the improvement methodology Working Together to Get Results which is a unique product with only one supplier.

Following a query from RH, the Director of Finance confirmed that Calderdale and Huddersfield Solutions Ltd (CHS) are subject to the same processes and that Procurement Department put in extra challenge. The Deputy Director of Finance added that CHS now hold the maintenance budgets so that waivers are cohorted in one place.

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

3. Bad Debt Write-Off

The Deputy Director of Finance presented the bad debt write-off report which contains debts which are proposed for write-off. In line with the delegated limits established by the Board of Directors, the write-off of any debt with a value of more than £1,000 is delegated to the Audit & Risk Committee for approval.

Having fully exhausted all options around debt recovery, the debt identified in the paper of £231k was recommended for write-off, all of which have been provided for in the Trust's financial statements. It was noted that there were no bad debt write offs in the previous financial year.

The debt recommended for write-off primarily relates to overseas visitors. Within this, there is one unusual debt of circa £100k which relates to an individual who was in the ICU for a significant period but was discharged well. A payment plan was agreed and a partial payment received but the patient is now sadly deceased and no estate was left, therefore no further route to pursue. As with all of the debts, this was chased through a number of methods then passed for debt collection, being mindful of the balance between chasing the debt and the Trust ethos of compassionate care.

RH asked if a more regular review should be undertaken. The Deputy Director of Finance advised that this would ordinarily be completed annually but it was not carried out last year due to the ongoing work through the Business Better than Usual route. AN agreed that the bad debts should be reviewed once a year as a minimum.

RH asked if the Trust was doing everything possible to minimise the write-offs, particularly in relation to overseas visitors. The Deputy Director of Finance advised that all possible means to chase bad debts were used but that the process of routine letters being sent out had lapsed for a period of time due to the change-over of financial system. The Trust was proactive in rectifying this with the system supplier.

DS asked if the refreshed process would address the issue relating to the Spire Hospital invoices. The Deputy Director of Finance advised that the contracts with private hospitals prove challenging due to contractual expectations and that the Trust processes have not been completely successful in assuring agreements are in place as an end to end process. Local private providers are still being pursued but the position is slightly different now due to the difference in pathways for recovery work.

OUTCOME: The Committee considered the debts identified in this paper and **APPROVED** their proposed write-off.

56/21 INTERNAL AUDIT

1. Internal Audit Follow Up Report

The Head of Internal Audit presented the follow up report which sets out the Trust-wide position on the implementation of Internal Audit recommendations which have fallen due during Q1 2021/22.

Good progress has been made on the implementation of internal audit recommendations which have fallen due during Q1. The final open 2016/17 recommendation has been actioned in the last quarter which has resulted in all actions for 2016/17 now either being implemented or closed as no longer applicable. Good progress has been made on the completion of both 2018/19 and 2019/20 recommendations with only 16 recommendations still outstanding in comparison to 77 in April 2021.

At the time of reporting 41 or 63% of the 65 open recommendations are overdue. However, it is noted that 17 or 26% of the open recommendations, including 14 that are overdue, relate to three audits reports where it was identified during the July follow up process that the responsible officer has left the Trust. We are liaising with the Trust to establish who will be responsible for ensuring these recommendations are actioned going forwards.

The Director of Finance expressed frustration at the number of overdue recommendations and advised that he has been raising this in a number of forums, outlining his concern that the actions have not been completed. Although it was

discussed at the Weekly Executive Board and led by the Chief Executive, it did not gain the traction expected. A discussion took place regarding the suggestion that sponsors/leads should be invited to an Audit and Risk Committee in order that the Committee can understand why actions are not being addressed. RH and DS both supported this suggestion. Another option would be for the Chair to write to the individual sponsors/leads. The Head of Internal Audit advised that in some organisations the Executive Directors/audit sponsors are routinely invited to the Audit and Risk Committee to talk about controls in their areas and their attendance leads to a better understanding of assurance required.

The Chair pointed out that it is not always easy to identify which recommendations relate to which year in the report and the Head of Internal Audit noted this comment.

The Chair suggested that a two step process is adopted, a letter to the sponsors/leads of the actions will be sent jointly from the Chair and the Director of Finance in the next few weeks and if no progress is achieved, the Medical Director and Director of Nursing will be invited to the next Audit and Risk Committee meeting.

Action: AN/Director of Finance to follow up with and where necessary write to the sponsors/leads of the outstanding internal audit recommendations. Should this action not prove successful then the relevant sponsors/leads will be invited to the next committee meeting

2.

Internal Audit Progress Report

The Head of Internal Audit presented the progress report which details the progress made by Internal Audit in completing the Internal Audit Plan since the last meeting in April 2021. Ten audit reports have been agreed with management

Copies of all high and significant assurance reports have been provided for information. Copies of the two limited assurance reports are contained within the progress report. Limited assurance reports have been finalised for HPS and Portable Medicines Trolley. RH advised that the HPS audit report will be reviewed at the next HPS Board meeting. He pointed out that this is the first occasion this has been undertaken and although there is a lot of work to be done, both he and the Director of Finance are confident that the actions will be completed and closed.

The Chair was encouraged to see how much progress has been made given the challenges of completing the 2020/21 audit plan.

OUTCOME: The Committee **APPROVED** the Internal Audit Follow Up Report and Progress Report and **RECEIVED** the significant and high assurance reports, the Insight reports for April – June 2021 and the Audit Yorkshire Internal Audit Charter.

57/21 LOCAL COUNTER FRAUD PROGRESS REPORT

Shaun Fleming, Local Counter Fraud Specialist presented the Local Counter Fraud progress report, annual report, and risk assessment. The key points to note were as follows.

1. Local Counter Fraud Progress Report

Presentations to colleagues are continuing to be delivered via Microsoft Teams and the Local Counter Fraud Specialist will be contacting managers to do tailored fraud presentations at department/team level concentrating on specific local fraud risks.

Audit Yorkshire are also running a series of fraud prevention masterclasses covering three key areas of recruitment, payroll and creditor payment frauds.

The Government has begun a post event assurance (PEA) exercise on centralised spending for the pandemic response. The NHS Counter Fraud Authority (NHSCFA) has been tasked by the Cabinet Office with conducting a PEA exercise focussing on NHS healthcare spend at a local level. Following the exercise, the NHSCFA will provide guidance based on lessons learned and outline any fraud vulnerabilities identified during the pandemic. THE NHSCFA's PEA will commence in late June 2021 and is applicable to NHS providers. Submissions are to be made by 23rd August 2021 and the Counter Fraud Team will be collating and submitting data to NHSCFA on behalf of the Trust.

2. Local Counter Fraud Annual Report

The NHSCFA has published guidance on how NHS organisations should aim to achieve compliance with the Government Functional Standard GovS 013: Counter Fraud CFFSR. All NHS organisations have been asked to provide a self-assessment to reflect performance against these requirements during the 2020/21 financial year. The NHSCFA has openly confirmed that it is expected that health bodies will record non-compliance against a number of components, and they have acknowledged that the provision of returns for 2020/21 will represent a baseline measurement that will enable organisations to identify work required to progress towards compliance by March 2022.

The LCFS has completed the CFFSR on behalf of the Trust. The proposed submission was then reviewed and signed off by the Director of Finance and Audit and Risk Committee Chair. The organisation has an overall rating of amber for 2020/21. The programme of works outlined in the Annual Counter Fraud Work Plan for 2021/22 will look to address the areas where amber or red ratings have been applied. A copy of the complete CFFSR submission summary for the Trust was attached to the report.

3. LCFS Risk Assessment

The Counter Fraud Risk assessment was provided for information. The paper considers current and emerging fraud risks for the Trust for 2021/22 and determines the direction anti-fraud work will take during the forthcoming financial year. The document seeks to identify high risk areas for the Trust and the identified risks feed into the 2021/22 Counter Fraud work plan.

The Chair asked if there were any specific risk areas for the Trust and the Local Counter Fraud Specialist confirmed there were no specific risks and no current fraud cases. In general, the main risks currently focus on cyber fraud and its prevention. The key preventative action being training and awareness. Take up for the classes is good for CHFT colleagues. The Deputy Director of Finance added that these masterclasses were well promoted within the Trust.

OUTCOME: The Committee **RECEIVED** the Local Counter Fraud Progress Report and **APPROVED** the Local Counter Fraud Annual Report and LCFS Risk Assessment.

58/21 BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the first update of the Board Assurance Framework (BAF) for 2021/22 which has been approved by the Board on 1 July 2021. Specific risks are reviewed by Board Committees at agreed timeframes. Sequencing for the rest of the year will give the Committee opportunity to review prior to Board.

There are currently 22 risks, with no new risks added since the last report presented; a number of risks have been reduced due to actions taken and one has increased – risk 7/19 compliance with NHS England/Improvement. This has been increased reflecting the financial challenge for the second half of the year.

RH advised that following discussion at the HPS Board on 19 July, it was clear that they are behind plan and the impact this might have on the commercial growth risk is therefore being assessed and might lead to reconsideration of the reduction of the risk that was made previously. The BAF risk had been reduced as a lower financial target had been set but there is a further gap emerging. The HPS Board have been tasked to produce a recovery plan which will be discussed at the next HPS Board meeting.

RH asked if the risk appetite assessment is reviewed annually or less frequently. The Company Secretary advised that this is generally reviewed in August. Last year this was done through dialogue with the Executive Directors, but she would welcome thoughts on how to undertake this review this year to widen participation. The Chair had made a suggestion which the Company Secretary will discuss with OW.

The Chair believes there is still more to do in terms of the gaps in control and gaps in assurance and there are some inconsistencies, but he will take this through the bi-weekly meeting with NEDs.

OUTCOME: The Committee **NOTED** the updated Board Assurance Framework as at 22 June 2021, noting the movement in risk scores and areas of risk exposure.

59/21 COMPANY SECRETARY'S BUSINESS

1. Reporting of conflicts of interest and standards of business conduct

The Company Secretary presented the report which details the current position on compliance with declarations of interest in line with the Trust's Conflicts of Interest and Standards of Business Conduct Policy. Work is taking place to develop individual reports by the current financial year, e.g. gifts declared in 2020/21, current outside employment with a proposed six months report to be presented to the next meeting on 13 October 2021. This was agreed and fits in with the end of the appraisal season. The Director of Finance asked if it is possible to benchmark the compliance rating for nil declarations. The Company Secretary advised that good progress had been made with nil declarations by March 2021 and this report would be circulated to members. **Action: AM to share report on nil declarations showing improved compliance position.**

OUTCOME: The Committee **NOTED** the declarations made and agreed the advice on the frequency of such reports.

2. Proposal of future Audit and Risk Committee dates 2022

The Company Secretary explained the proposal of future dates of the Audit and Risk Committee for 2022 were attached for approval. The Company Secretary asked that if there any issues with the dates, members should inform her.

OUTCOME: The Committee **APPROVED** the future Committee meeting dates for 2022.

3. Review Audit and Risk Committee Workplan

The Company Secretary stated the Committee workplan was attached for approval and any changes are to be notified to the Company Secretary or Corporate Governance Manager.

OUTCOME: The Committee **APPROVED** the annual workplan for 2021.

4. External Audit Appointment Process – Andrea to complete from here

Jenny Langdon, KPMG, declared an interest in this item and left the meeting.

The Company Secretary shared the report which outlines the process and timeline for the appointment of an external auditor given the expiry of the contract with the current audit provider, KPMG on 31st October this year. The audit scope will include CHFT annual accounts, CHS annual accounts and the accounts for the Trust's charity, as now.

It was confirmed that the appointment is made by governors and currently expressions of interest had been requested for two governors to be involved in the procurement. AN as Chair of this Committee and finance and procurement colleagues will also be involved. RH advised that he was happy to be involved in the process as required.

It was noted that a procurement framework agreement is in place for external and internal audit and this would be used. There are five providers on this framework.

The fragile external audit market for the public sector was noted. The next steps in terms of an external audit specification review and sign off with governors, consideration of expressions of interest from providers and a recommendation to the Council of Governors in October 2021 were noted.

OUTCOME: The Committee **NOTED** the requirement for the appointment of an external auditor and the process and timeline detailed in this paper.

60/21 SUMMARY REPORTS AND MINUTES TO RECEIVE

A summary report of work undertaken since April 2021 was provided for the following groups and minutes were circulate for assurance:

- Risk Group – no questions were raised.
- Information Governance and Records Strategy Group – MG highlighted the need to achieve 95% compliance with the IG training target, noting compliance is around 93-94%. The Data Security and Protection Toolkit was submitted on 30 June 2021 as 'standards met' as the Trust has been given grace on reaching the 95% target. Focus is on achieving the target in the next few weeks and once 95% compliance is achieved, a snapshot report can be taken and submitted. RH noted the ICO data breach incidents referenced in the highlight report and queried how frequent these were. MG advised these do not happen regularly but do happen and that serious incident investigations were underway for these incidents.
- Health and Safety Committee – AN noted the report was brief.
- Data Quality Board – no questions were raised.
- CQC and Compliance Group – AN noted the content was mixed in terms of level of detail by division and asked DS if this was the same at the Quality Committee, which receives the minutes regarding the CQC work of the group. DS noted only one report had been received by the Quality Committee to date since the revised

reporting arrangements were agreed and advised she will review what's coming through and ensure information is received in a way that gives assurance.

OUTCOME: The Committee **NOTED** the summary reports for the above groups.

61/21 ANY OTHER BUSINESS

There was no other business.

62/21 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Health and Safety Deep Dive
- Bad debt write off
- Internal Audit and further action required on overdue recommendations, encouraging progress with audits this year
- Board Assurance Framework – further work to do on gaps in controls and actions
- Data Security Protection Toolkit and importance of achieving 95% Information Governance training compliance

63/21 DATE AND TIME OF THE NEXT MEETING

Wednesday 13 October 2021
10:00 – 12:15 pm
Microsoft Teams

64/21 REVIEW OF MEETING

The meeting closed at approximately 12:17 pm.

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 2:00 PM ON THURSDAY 15 JULY 2021 VIA MICROSOFT TEAMS

PRESENT:

PUBLIC ELECTED GOVERNORS

John Gledhill	Public Elected – Lindley and the Valleys
Christine Mills	Public Elected - Huddersfield Central
Stephen Baines	Public Elected – Skircoat and Lower Calder Valley (Lead Governor)
Alison Schofield	Public Elected – North and Central Halifax
Sheila Taylor	Public Elected – Huddersfield Central
Annette Bell	Public Elected – East Halifax and Bradford

STAFF ELECTED GOVERNORS

Linzi Smith	Staff Elected – Management / Admin / Clerical

APPOINTED GOVERNORS

Cllr Lesley Warner	Kirklees Metropolitan Council
Prof Joanne Garside	University of Huddersfield
Salma Yasmeen	South West Yorkshire Partnership Foundation Trust
Robert Dadzie	Calderdale and Huddersfield Solutions Ltd
Cllr Megan Swift	Calderdale Metropolitan Council

IN ATTENDANCE:

Karen Heaton	Acting Chair / Non-Executive Director
Alastair Graham	Non-Executive Director
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager (minutes)
Sarah Mackenzie-Cooper	Equality and Diversity Manager, Calderdale CCG

41/21 APOLOGIES FOR ABSENCE

Philip Lewer	Chair
Helen Barker	Chief Operating Officer
Owen Williams	Chief Executive
Gary Boothby	Executive Director of Finance
Helen Hunter	Healthwatch – Kirklees and Calderdale
Lynn Moore	Public Elected - North and Central Halifax
Veronica Woollin	Public Elected - North Kirklees
Chris Reeve	Locala
Brian Richardson	Public Elected - Skircoat and Lower Calder Valley
Jude Goddard	Public Elected – Calder and Ryburn Valleys

42/21 WELCOME & INTRODUCTIONS

Karen Heaton, Acting Chair welcomed Peter Keogh, Kirsty Archer, governors and colleagues from the Board of Directors to the Council of Governors meeting.

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Karen Heaton welcomed Sarah Mackenzie-Cooper, Equality and Diversity Manager to the meeting who was in attendance from the Calderdale Clinical Commissioning Group (CCG) as a public observer.

43/21 DECLARATIONS OF INTEREST

The Acting Chair reminded the Council of Governors and staff colleagues to declare their interest at any point in the agenda.

44/21 MINUTES OF THE LAST MEETING HELD ON 22 APRIL 2021

The minutes of the previous meeting held on 22 April 2021 were approved as a correct record.

OUTCOME: The minutes of the previous meeting held on 22 April 2021 were **APPROVED** as a correct record.

45/21 MATTERS ARISING / ACTION LOG

There were no matters arising and no outstanding actions on the action log.

OUTCOME: The Council of Governors **NOTED** there were no outstanding actions on the action log.

46/21 FEEDBACK FROM NON-EXECUTIVE DIRECTORS IN ATTENDANCE – KAREN HEATON AND ALASTAIR GRAHAM

Alastair Graham

Alastair introduced himself who joined the Trust approximately four years ago and outlined the Board Committee work he has been involved in via the Research and Innovation (R&I) Committee, Transformation Partnership Board, and his role Chairing Calderdale and Huddersfield Solutions Ltd (CHS).

CHS Chair – Alastair explained CHS provides estates and facilities management at the Trust which includes medical engineering, maintaining equipment etc. He explained there are a series of service level agreements (SLAs) and almost all of the key performance indicators (KPIs) have been met. CHS managed to achieve a donation of £0.5m to the Trust's charity. He explained how busy it has been for CHS during the pandemic where CHS developed a new isolation ward from ward 18 in record time. CHS ensured PPE was available to all staff and cleared the snow and ice during winter months. He explained CHS undertake 'Gold star awards' where he hears fantastic stories of staff who have gone the extra mile. Alastair explained CHS have taken over the contract for Acre Mills and will be taking over the catering contract for Spice of Life at Huddersfield Royal Infirmary.

R&I Committee member – Alastair explained CHFT has been one of the leaders in terms of the recovery trial and received a national award. The Trust recruited many volunteers to the programme which resulted in an effective treatment of Covid-19 which is a credit to the Trust. He added the Trust are partnering with the commercial sector to trial new approaches.

Transformation Partnership Board member – Alastair explained the Trust have recently submitted the planning application for the new A&E for Huddersfield Royal Infirmary and subject to the planning consent, the new A&E Department will be built. He added the planning application for Calderdale Royal Hospital is imminent this

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month for a brand-new multi-story car park. He stated that staff and the public are looking forward to the new hospital provision at both sites.

Christine Mills highlighted the amount of courage it takes to go back into the hospital following isolation and she recently thanked a cleaner in the hospital who responded she was the first patient to thank them. Christine wanted to pass on the importance of cleaners at the Trust who had to work in high-risk areas during the pandemic and that their work shouldn't go unnoticed. Christine's comment had been shared with Stuart Sugarman, CHS Managing Director and Alastair agreed to follow this up and added the cleaners have made a huge impact for infection control and minimising outbreaks. Linzi Smith agreed and added that the cleaner at Park Valley Mills had to work in different areas in the hospital and go into areas where they didn't feel safe. She stated they do a sterling job and don't get enough appreciation.
Action: Alastair Graham to check with Stuart Sugarman that he has passed on the thank you to the cleaners for all their hard work and impact they have had during the pandemic.

Karen Heaton
Karen explained that the Non-Executive Directors have continued to meet fortnightly and review updates from the Chief Operating Officer, Director of Nursing, and the Chief Executive.
She explained a Perinatal Quality Surveillance Group has been set up and two meetings have taken place so far. There has been an agreement to widen the scope of this group to focus wider than maternity services as a holistic approach. Karen is the NED lead for Maternity and explained she would like to visit the services on site once it is safe to do so.

Workforce Committee Chair – Karen outlined the following work of the Workforce Committee:

- Feedback on the equality, diversity and inclusion (EDI) process
- Freedom to Speak Up – increasing numbers of staff are using this route which is positive (safer environment); however, the majority are still anonymous, there is still work to do
- Focus on recruitment and retention, business better than usual and the workforce
- Sickness absence levels which have been decreasing recently but started to increase in relation to self-isolation levels (track and trace)
- Visited the performance metrics and the Board Assurance Framework
- Deep dive into leadership and management competencies post covid and what this means in terms of the overall strategy
- Results of the annual staff survey – national picture is to continue with annual surveys and introduce pulse surveys – Karen raised a risk of over surveying staff at the Board meeting

Prof Joanne Garside asked if the Trust are getting a higher rate of staff leaving (retention) and if any flags have been raised in the Trust. Karen responded not at the moment and added how important it is for the Trust to recruit staff as soon as possible where there is a vacancy to release pressure from vacancies. Karen explained there is an international recruitment campaign currently taking place to release some of this pressure with nurses. Karen added there is still the option for staff to take early retirement which is a concern that the Trust will keep sight of.

OUTCOME: The Council of Governors **NOTED** the feedback from the Non-Executive Directors.

PERFORMANCE AND STRATEGY

47/21 Annual Plan 2021/2022

The Deputy Director of Finance presented the annual plan for 2021/22. The key updates were:

- Different position for financial funding compared to business as usual
- Moved into a funding regime where the Trust receive blocked funding (fixed amounts) for clinical activity and Covid requirements which has continued for the first half of this year
- Less certainty in the second half of the financial year which won't be clear until September due to receiving information late compared to normal timescales
- First half 2021/22 planning a breakeven position (no surplus, no deficit)
- Total income across the year amounts to roughly £460m with a plan to spend all this income
- The Trust need to deliver some efficiency during the first half of the year, low level of roughly £3m recognising operational pressures
- Second half of the year, based on assumptions, is considerably more challenging due to an expected increase in the efficiency challenge which is recognised nationally
- Regime in place where the Trust will be awarded additional funding for Elective Recovery (day case, backlogs) activity and thresholds which increase month on month
- Planning for £4.3m of elective recovery funding – fluctuating each month
- Capital – investing in our estate / IT / medical equipment – planning to spend just under £19m on these investments during the course of the year, some of this relates to the commencement of reconfiguration
- Cash position is healthier than previously due to the certainty of the financial regime being paid in block payments on clinical activity where there are no delays and the write off of legacy debts last year which were converted to public dividend capital
- Opening cash balance of £48m – continue to maintain these healthy cash balances

Karen added that is it a requirement to consult on the annual plan with governors and the Trust would have normally shared this information with governors earlier in the year; however, this has been delayed as a consequence of Covid-19.

Linzi asked if there is any change in the PFI agreement in terms of the reconfiguration. The Deputy Director of Finance confirmed the write off of debt is separate to the PFI, this was related to the borrowing deficit (overspend) in year. The Deputy Director of Finance confirmed there is no change to the PFI arrangement, and the Trust continue to pay bills to the PFI provider for the provision of services at Calderdale Royal Hospital (CRH).

OUTCOME: The Council of Governors **NOTED** the update on the Annual Plan for 2021/2022.

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48/21 Operational Update and Recovery Plans

Peter Keogh, Assistant Director of Performance presented the operational update and recovery plans. The key updates were:

- Covid position – Continue to see an increase in the patients attending and who are admitted with Covid and currently have 24 inpatients with 3 in ICU, 1 patient sadly died in the last week
- There is a definite shift to a younger age group and the majority of patients now being admitted have not had their vaccine.
- Lifting of restrictions on Monday 19th July will not apply to healthcare settings, it is important to keep patients safe and comply with infection control measures
- Emergency Department (ED) pressures – significant and continued increase in demand for both ED departments since the second half of March 2021, numbers never seen before e.g., over 600 patients per day between the two ED Departments compared to roughly 450 previously
- Not all ED attendances are converted to inpatients – there has been a reduction
- Clinical feedback around patients presenting includes increased acuity and complexity as a result of not accessing services and deconditioning during the Covid-19 period and this is being explored
- April – June this year compared to 2 years ago, 9% increase overall in increased acuity (complexity) although admissions through ED are similar
- Stroke – gaining access to a stroke bed within 4 hours has deteriorated due to a steep rise of admissions and CT scanner problems at CRH which impacts on timeliness of scans and subsequent admission into the stroke bed base, slight improvement in June position with a dedicated stroke bed, hope to see some improvements
- Cancer performance has been excellent during the last 16 months during the pandemic which has been maintained pre-pandemic – one of the top 10 performing Trusts – now seeing a step change in referrals which is causing some pressure with diagnostic capacity and is being reviewed
- Length of stay increase in numbers of patients with a length of stay over 50 days and the complexity of needs noted – unusually high number of younger patients in this category (under 60's)
- Out of hospital capacity is struggling to manage increases in demand, both health and social care impacting on the number of delayed transfers of care
- Community services are seeing more complex and acute presentations – further work required to embed use of acuity and complexity models
- Recovery – Plans in place for the year with targets set end of September and March – meetings taking place several times per week to look at activity and impact of patients
- Priority 2 (P2) and Priority 3 (P3) categories are a focus with the plan to see all P2's within 4 weeks and all P3's within 12 weeks of being listed
- Priority 4 (P4) category – a 12 week average referral to treatment time waiting time reduction for P4's, treating by exception where there are gaps
- More patients are being added to the waiting lists than are being taken off
- Reviewing waiting list initiatives, outsourcing to other providers and allowing other providers to use our services with support from CCG colleagues – starting with ENT and testing the model here

- Before Covid-19 the Trust had no 52 week waiters – this has increased over the last 12 months
- Leading on health inequalities with no variation in waiting times by ethnicity and learning disability patients are being prioritised
- 85% of adult patients with a learning disability have now been treated and all children with a learning disability have been identified on the waiting list
- CHFT are being recognised nationally for the work they are doing on learning disabilities in relation to health inequalities
- Delivering more activity than plan
- Challenge with sickness, particular in theatres where there are staff sickness and vacancies
- Struggle with uptake of additional activity – staff fatigue
- Trajectories in place are reviewed weekly and may be revised

49/21 Performance Update

Peter Keogh, Assistant Director of Performance presented the performance update for May/June 2021. The key updates were:

- 71% overall performance in May 2021 – 3 domains Green are safe, caring and effective
- Finance and workforce were close to green
- Excellent performance during particularly challenging time
- Response domain is the most challenging in terms of recovery and ED performance
- Workforce – sickness absence has been good overall and improved over last few months, still areas of long-term sickness which needs addressing
- 100% response rate to complaints were achieved in May – excellent achievement – the Trust are negotiating timescales with families to achieve this
- Friends and Family Test (FFT) - 4 out of 5 areas are green in May, maternity was amber – all 5 areas are green in June which is a great response and shows the treatment patients are receiving
- Emergency care – seeing high rates of admissions, still performing well
- Good news stories from each of the Divisions are included in the slides

Linzi asked if every single complaint received gets acknowledged with a written response and asked what the exact timeframe was to respond. The Assistant Director of Performance confirmed all complaints receive a written response and believes the timeframe is 20 working days to respond. The Company Secretary added that an acknowledgement of a complaint is sent within 2 days of it being received. She added the internal deadline used to be 20 working days or up to 40 days if the complaint is complex however now deadlines for response are negotiated with the complainant, which is in line with the national framework for complaints.

Christine Mills provided positive feedback regarding a recent complaint, that she recently filled in a complaint form and received a response at 9am the following morning and the complaint was sorted within 2 days.

OUTCOME: The Council of Governors **NOTED** the Operational Update, Recovery Plans and Performance Update.

50/21 Financial Position and Forecast – Month 2

The Deputy Director of Finance summarised the key points in the month 2 finance report which were as follows:

- Year to date the Trust has delivered a surplus of £3.3m – a favourable variance of £2.94m compared to plan (good news) – breakeven by the end of the first half of the year
- Surplus and better than plan position is due to slippage of developments, vacancies and lower than planned recovery costs – most significant is the higher than planned elective recovery funding
- Next few months are more challenging as elective funding targets increases
- Agency expenditure – spent more than planned year to date (YTD)– NHS improvement agency trajectory target was paused – the Trust have set their own internal target which the Trust are over – not being scruitinised currently, this is partly due to pressures in ED
- Cash position is healthy and enabling the Trust to pay invoices – target is 95%, hit 93% YTD which is slightly below target but a massive improvement on recent years

The Deputy Director of Finance explained 'Managing Our Money' training has previously been offered to governors and this offer can be extended if governors are interested. There was discussion that this might be helpful for the newly elected governors.

OUTCOME: The Council of Governors **NOTED** the Month 2 Financial Summary for 2020/21.

QUALITY UPDATE

51/21 Update on 2021/22 Quality Priorities and Quality Update

The Director of Nursing provided a detailed presentation giving a Quality update and an update on the 2021/22 Quality Priorities. The presentation focused on the topics below and will be circulated with the minutes:

- Care Quality Commission
- Journey to Outstanding
- Maternity Safety
- Quality Priorities
- Making Complaints Count

Stephen Baines re-iterated there is a strong case for balancing complaints with the number of compliments the Trust receives which will give an idea of the true balance. The Director of Nursing agreed to include compliments in the next update and explained the Friends and Family Test was stood down during the pandemic. She added the feedback from the 'Observe and Act' has largely been positive.

Action: Director of Nursing to include data on compliments in the next update

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Karen thanked the Director of Nursing for her comprehensive presentation.

OUTCOME: The Council of Governors **NOTED** the Quality update and update on the 2021/22 Quality Priorities.

52/21 UPDATE FROM COUNCIL OF GOVERNORS SUB-COMMITTEE

Nominations and Remuneration Committee held on 19 April 2021 and 1 July 2021

The minutes were presented and Stephen Baines confirmed these accurately reflect the discussion. He added that Philip is well respected by the governors and does a very good job as Chair.

The Company Secretary confirmed at the meeting on 19 April 2021, two Non-Executive Directors tenures were extended for 12 months to 2023 and agreed by the Committee. These were Karen Heaton who has supported the Workforce Committee and agenda which has been challenged over the pandemic and Richard Hopkin who supports the financial business of the Trust.

OUTCOME: The Council of Governors **APPROVED** the minutes of the Nominations and Remuneration Committee (CoG) meeting held on 19 April 2021 and 1 July 2021.

53/21 CHAIR'S REPORT

Karen Heaton, Acting Chair provided an update on the pressures currently being faced in the ED Departments and explained several patients are waiting over 12 hours in ED. She added there will be additional pressure on the system post 19 July when restrictions are lifted. Karen explained a system Gold meeting has been convened due to the delayed number of transfers of care. There is lots of pressure on the system and staff, who have been doing an outstanding job. All staff have contributed and made a sacrifice.

OUTCOME: The Council of Governors **NOTED** the Chair's updated provided by Karen Heaton as Acting Chair.

GOVERNANCE

54/21 UPDATE FROM LEAD GOVERNOR/CHAIR

Stephen Baines had no further update to share and highlighted the notes from the meetings he has with the Chair are circulated to all governors.

55/21 Outcome of Chair's Appraisal

A report detailing the outcome of the Chair's appraisal was shared with the papers. The Acting Chair shared the key messages which were:

- Feedback was sought from a range of stakeholders across the Trust and wider system

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- Appraisal process was undertaken using the national guidance on the appraisal process for NHS Chairs
- High response rate of 83% with very positive feedback – thanks to governors for their contributions
- Appraisal was undertaken by Richard Hopkin as Senior Independent Non-Executive Director (SINED) and the appraisal was completed by the end of June 2021
- The outcome was shared with NHS England/Improvement and the Nominations and Remuneration Committee on 1 July 2021
- Areas of strength and areas of focus were discussed with overall and well-deserved feedback

OUTCOME: The Council of Governors **NOTED** the outcome of the Chair's appraisal.

56/21 Thank you to outgoing governors

The Acting Chair thanked the outgoing governors for their commitment and contribution to the Trust by way of governor. The outgoing governors are:

- Annette Bell, Publicly elected governor
- Lynn Moore, Publicly elected governor
- Brian Richardson, Publicly elected governor
- Jude Goddard, Publicly elected governor
- Sheila Taylor, Publicly elected governor
  Linzi Smith, Staff elected governor
- Rosie Hoggart, Staff elected governor

All outgoing governors will receive a certificate in recognition of their contribution as a governor at Calderdale and Huddersfield NHS Foundation Trust and a letter from Philip in due course.

There will be a full induction programme for the new governors who will be welcomed at the Annual General Meeting on 28 July 2021. Details of the election results were shared with members in the recently issued Foundation Trust News and will be shared at the AGM, with a new register of governors presented at the Council of Governors meeting in October 2021.

57/21 COMPANY SECRETARY'S REPORT

a. Outcome of Lead Governor Appointment

The Company Secretary shared the outcome of the annual lead governor role received one nomination from the current lead governor, Stephen Baines. Stephen will be in the lead governor role for the next July to July 2022 period.

The Company Secretary thanked Stephen for his nomination.

OUTCOME: The Council of Governors **APPROVED** the outcome of the lead governor appointment.

b. Proposal of Council of Governor Meeting Dates for 2022

The Company Secretary explained the proposal of future Council of Governors meeting dates for 2022 have been shared for approval with the revised timings of the meetings.

OUTCOME: The Council of Governors **APPROVED** the Council of Governors meeting dates for 2022.

c. Appointment of External Auditor and Timeline

The Company Secretary reported the Trust have an external auditor, KPMG, who have been working with the Trust for four years and are now at the end of their contract.

The paper circulated describes the procurement process for a new external auditor and role of the governors in making the appointment. The Company Secretary explained volunteers from the governors are sought for the process to be complete by the end of September with the outcome reported to the Council of Governors meeting on 21 October 2021 for ratification.

The Company Secretary explained the market for external auditors is very fragile at the moment and not much interest is expected. A framework approach will be used where a number of providers have already been recognised on a value for money basis.

Any interested governors are asked to inform the Company Secretary by Friday 23rd July with a first meeting taking place around the first week of August 2021. A guide explaining governors role and the external auditor appointment process was included in the paper.

Cllr Lesley Warner asked if KPMG can be re-appointed. The Company Secretary confirmed there are five providers and KPMG are one of the companies who can bid for the work again; however, this will need to go to a bid for comparison. Karen Heaton emphasised the challenge in this market and the difficulty in appointing auditors.

OUTCOME: The Council of Governors **NOTED** the update on the appointment of an external audit and the timeline and **NOTED** that expressions of interest in this process from governors required by Wednesday 28 July 2021.

58/21 RECEIPT OF MINUTES FROM SUB-COMMITTEES

The minutes of the following meetings were received:

- Quality Committee held 19.04.21 & 24.05.21
- Workforce Committee held 10.05.21
- Charitable Funds Committee held 24.05.21
- Audit and Risk Committee held on 12.04.21 & 10.06.21
- Finance & Performance Committee held on 29.03.21 & 05.05.21

No questions were raised.

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OUTCOME: The Council of Governors **RECEIVED** the minutes from the above sub-committee meetings.

59/21 INFORMATION TO RECEIVE

a. Council of Governors Workplan 2021
The Council of Governor's Workplan for 2021 was circulated for information.

b. Council of Governors Calendar 2021
The Council of Governor's calendar of meetings for 2021 was circulated for information. This includes all governor meetings, workshops, and Divisional Reference Groups for 2021.

OUTCOME: The Council of Governors **RECEIVED** the Council of Governors Workplan for 2021 and the Council of Governors meeting dates for 2021.

60/21 ANY OTHER BUSINESS

The Company Secretary asked the governors for their views on how they found the new time of the meeting. One governor noted a later time is better for her, several others noted d the earlier timings work best for them. It was agreed that meetings will continue at the earlier time for now.

Stephen Baines formally thanked Karen for stepping in as Chair for Philip Lewer due to his leave and expressed his appreciation for the amount of work Karen Heaton and the Non-Executive Directors put in over and above what is required.

Karen thanked Stephen Baines and the governors for their participation.

DATE AND TIME OF NEXT MEETING

The Acting Chair thanked all the Council of Governors, Non-Executive Directors and Executive Directors for attending the meeting and their contribution and formally closed the meeting at approximately 3:58 pm and invited governors to the next meetings.

Council of Governors Meeting

Annual General Meeting
Date: Wednesday 28 July 2021
Time: 5:00 – 6:30 pm
Venue: Virtual via Microsoft Teams

Date: Thursday 21 October 2021
Time: 2:00 – 4:00 pm (Private meeting 1:00 – 1:45 pm)
Venue: Microsoft Teams

DRAFT

Draft Minutes of the Calderdale and Huddersfield NHS Foundation Trust Board of Directors and Council of Governors Annual General Meeting held Wednesday 28 July 2021 at 5:00 – 6:30 pm Via Microsoft Live Events

PRESENT

Speakers
Philip Lewer, Chair
Owen Williams, Chief Executive
Gary Boothby, Executive Director of Finance
Suzanne Dunkley, Executive Director of Workforce and Organisational Development
Ellen Armistead, Executive Director of Nursing
Stephen Baines, Lead Governor, Publicly Elected, Skircoat and Lower Calder Valley

Board of Directors
Helen Barker, Chief Operating Officer
David Birkenhead, Executive Medical Director
Stuart Sugarman, Managing Director, Calderdale and Huddersfield Solutions Ltd
Andy Nelson, Non-Executive Director
Richard Hopkin, Non-Executive Director
Denise Sterling, Non-Executive Director
Peter Wilkinson, Non-Executive Director

In Attendance
Andrea McCourt, Company Secretary
Jackie Ryden, Reconfiguration Programme Governance Lead
Danielle Booth, Admin Assistant, Membership and Engagement
Richard Hill, Senior Collaboration Specialist, ICT
Rashpal Khangura, External Audit Partner, KPMG

Public Elected Governors
Annette Bell, Public Elected Governor, East Halifax and Bradford
Christine Mills, Public Elected Governor, Huddersfield Central
Veronica Woollin, Public Elected Governor, North Kirklees
John Gledhill, Public Elected Governor, Lindley and the Valleys
Lynn Moore, Public Elected Governor, North and Central Halifax
Sheila Taylor, Public Elected Governor, Huddersfield Central

Staff Elected Governors
Linzi Smith, Staff Elected, Management / Admin / Clerical

Appointed Governors
Salma Yasmeen, South West Yorkshire Partnership NHS Foundation Trust

Apologies
Anna Basford, Director of Transformation and Partnerships
Mandy Griffin, Managing Director, Digital Health
Alastair Graham, Non-Executive Director

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Karen Heaton, Non-Executive Director

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chair opened the meeting by welcoming everyone to the second 'virtual' Annual General Meeting of the Council of Governors which covers the period April 2020 to March 2021 and provides an opportunity to reflect on the last 12 months within the Trust and share the Trust's plans and challenges for the coming year.

The Chair welcomed the Executive Directors, Non-Executive Directors, Lead Governor and the governors who were part of the virtual audience.

The Chair also welcomed the external auditor, Rashpal Khangura from KPMG. The external auditors play a vital role auditing the annual report and accounts each year before they are submitted to Parliament. The Chair advised that both the annual report and accounts and an easy read short version of the annual report for 2020/21 are available on the Trust website. The quality accounts for the year can also be found on our website, these describe the quality of services we delivered to our patients over the past year.

The Chair stated that the governors have a key role in appointing the Non-Executive Directors at the Trust and have just agreed that two of our current Non-Executive Directors, Karen Heaton and Richard Hopkin will continue as Non-Executive Directors for up to a further 12 months to February 2023.

A recording of the AGM can be found at https://www.cht.nhs.uk/publications/annual-reports-and-annual-general-meeting/

2. OVERVIEW OF THE COUNCIL OF GOVERNORS CONTRIBUTION 2020-2021

Stephen Baines introduced himself as the Lead Governor at CHFT since December 2019 and explained he has recently been successfully re-elected as lead governor for a further year.

Stephen said he really enjoys his time as a Governor for the Trust and this past year has been 'A year like no other' for the Council of Governors who quickly transitioned to virtual meetings during the pandemic. Stephen thanked the governors for how engaged they have been during this past year with virtual meetings taking place as they have made it very successful and shows how committed they are in their governor role and helping the Trust.

Stephen explained the prime duty of the governors is to ensure that the Non-Executive Directors effectively challenge the other Board Directors in all matters regarding the work of the Trust. The governors do this by attending the Board meetings, the Boards sub committees and the Non-Executive Directors attend the Council of Governors meetings and report on their work and answer questions.

During this last year, Governors have had the opportunities to attend a number of workshops with the Non-Executive Directors and Board Directors to discuss:

- Service Reconfiguration and Estate Developments at CRH and HRI

- Quality Account Priorities
- Development with the Integrated Care System (ICS)
- Cancer performance
- How the Trust are driving the agenda for health inequalities focusing on patients with learning disabilities.

This year, thanks to the excellent support staff provided for the governors, governor videos were introduced which give an insight into the work of the governors and these videos are available on the Trusts website here: https://www.cht.nhs.uk/about-us/membership-and-the-council-of-governors

Given the operational pressures during the past year, governors received information from Divisions about what was happening rather than meeting with Divisions face to face.

A couple of our governors and members have been helping the Trust pilot a patient experience tool called 'Observe and Act' focusing on inpatient care to look at where improvements could be made for patients. We look forward to continuing this over the next year with their support.

The annual Governor elections in July 2020 were cancelled and the Governors whose term had ended last year willingly served an extra 12 months. Stephen took this opportunity to thank all the Governors and the Governors who stayed for a further 12 months for their contributions and commitment during the year.

The annual Governor elections for 2021 took place earlier this year and was very successful, the results will be shared shortly. Stephen expressed special thanks to the outgoing public elected governors:

- Jude Goddard, Calder and Ryburn Valleys
- Sheila Taylor, Huddersfield Central
- Brian Richardson, Skircoat and Lower Calder Valley
- Lynn Moore, North and Central Halifax
- Annette Bell, East Halifax and Bradford

Stephen also expressed special thanks to the outgoing staff elected governors:

- Linzi Smith, Management/Admin/Clerical
- Rosie Hoggart, Nurses/Midwives
- Peter Bamber, Drs/Dentists

Stephen thanked all the outgoing governors for their excellent contribution during the year.

Stephen also thanked Andrea McCourt, Amber Fox, Jacqueline Ryden, Vanessa Henderson and Danielle Booth from the Trust Corporate team for their help and guidance and arranging all the meetings along with Philip Lewer for Chairing the meetings and continuing in his second tenure as Chair. Stephen also thanked all the Non-Executive Directors for their updates and work at the Trust.

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3. ELECTION RESULTS 2021 AND APPOINTMENTS

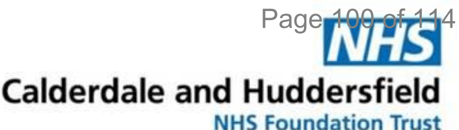
Philip Lewer, Chair stated the governor elections for 2021 were very successful and he confirmed the following governors have been elected this year:

Constituency	**Public Elected Governor**
Calder and Ryburn Valleys	Peter Bamber
	Gina Choy
Huddersfield Central	Christine Mills
	Robert Markless
South Huddersfield	Isaac Dziya
Skircoat and Lower Calder Valley	Nicola Whitworth
East Halifax and Bradford	Peter Bell
North and Central Halifax	Alison Schofield
	Chris Matejak
Lindley and the Valleys	Brian Moore

Constituency	**Staff Elected Governor**
Nurses/Midwives	Liam Stout
Nurses/midwives	Jason Sykes
Management/Admin/Clerical	Emma Kovaleski
Drs/Dentists	Sandeep Goyal
Ancillary	Jo Kitchen

4. a) HEALTH INEQUALITIES AND LEARNING DISABILITIES

Owen Williams, Chief Executive expressed his heartfelt thanks to colleagues and patients, friends and relatives for the way that they have stood together during this unbelievably challenging year. He highlighted the sheer commitment, passion and fortitude shown by colleagues will never be forgotten.



The Chief Executive shared a few significant achievements made by CHFT in working with the local community and partners in tackling health inequalities. He explained the four key themes of this work were:

1. External Environment: Connecting with our Communities
2. Lived Experience: Maternity
3. Using our data to inform stabilisation and reset
4. Diverse and inclusive workforce

Owen advised anyone who would like to know more about the Trust's work on health inequalities to watch the recording of the most recent Board of Directors meeting which took place on 1 July 2021, available on our website, as this provides more context and demonstrates the Board of Directors appetite to tackle health inequalities.

Owen Williams introduced a short video which highlights the work the Trust have been doing in respect of striving for equality for people with a learning disability.

b) HOW COLLEAGUES EMBRACED ONE CULTURE OF CARE (TAKING CARE OF EACH OTHER) THROUGHOUT THE PANDEMIC

Suzanne Dunkley, Executive Director of Workforce and Organisational Development explained how proud the Trust have been in colleagues throughout the pandemic and how important health and wellbeing of colleagues is, which was referred to as 'One Culture of Care'. Suzanne introduced a short video which was made to show how colleagues embraced one culture of care (taking care of each other) throughout the pandemic.

5. FINANCIAL REVIEW: ANNUAL ACCOUNTS: APRIL 2020 – MARCH 2021 AND THE EXTERNAL AUDIT OPINION

Gary Boothby, Executive Director of Finance presented a financial report for 2020/21, highlighting the key points from 2020/21 and looking forwards to 2021/22. The Executive Director of Finance advised that full details of the annual accounts were available in the 2020/21 Annual Report which was published on the Trust website.

Overall, the year ending 31 March 2021 was a successful year for the Trust in that a £360k financial surplus (underspend) was delivered, compared to an original target of £1.92m deficit (overspend). The year was closed with significantly lower outstanding loans compared with previous years and less spend on external agency staff than planned and the target set by our regulators. He highlighted this is the second consecutive year that the Trust has managed to balance the books and deliver small surpluses.

The Executive Director of Finance explained changes to the funding regime in year were very supportive in ensuring that services were being maintained and patient care was provided. The actual operational expenditure for the year was £44m higher than planned and in year funding was provided by the NHS to support the Covid

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response. There was also no longer a requirement to deliver high levels of efficiency savings and it was recognised that all clinical and operational teams were focused on responding to the pandemic and care for patients.

The Executive Director of Finance described some of the capital investment in year which included a Ward 18 refurbishment into a state of the art 15 bed isolation ward as part of the Covid response, and a new aseptic suite at Calderdale Royal Hospital which allows the Trust to centralise and prepare sterile products for patients and photos of these new developments were shared.

The Executive Director of Finance presented the External Audit Opinion from KPMG who considered the following and provided an unqualified (clean) audit opinion:

- Financial statements
- Value for money position
- Whole of Government's Accounts
- Annual Report

The Executive Director of Finance shared the future position for 2021/22. The Trust plan to deliver a break-even position in the first half of the year with an efficiency target of £3m. The financial regime for the second half of the year is currently unknown and will be assessed in September 2021.

6. CHFT WORKING WITH PARTNERS IN KIRKLEES AND CALDERDALE PLACE AND THE INTEGRATED CARE SYSTEM

Ellen Armistead, Deputy Chief Executive / Executive Director or Nursing explained one of the key values of the Trust is working together to get results. She explained CHFT are part of a health and care system and highlighted the importance of working in partnership to improve outcomes for our population and protecting our most vulnerable.

She explained PLACE based partnerships have been at the heart of being able to respond to the pandemic and have resulted in bringing several organisations, inclusive of the voluntary and community sector, together. She explained the wider team responded brilliantly and extra support was provided into the care home sector and in reducing delayed transfers of care.

CHFT are part of a West Yorkshire Association of Acute Trusts which is a forum for physical acute Trusts in West Yorkshire and Harrogate (WY&H) and provides for a single voice into Regional and National matters. Delivery is primarily focused on acute trust improvement programmes and facilitates clinical, operational collaboration and mutual aid which has been invaluable these last several months. Areas for future development will include, for example, WYAAT peer review of maternity services as a part of the response to the Ockenden review (to improve safety in maternity for mums and babies) as well as working on creating regional resilience across services such as non-surgical oncology.

CHFT is playing its part in contributing to the big 10 ambitions for West Yorkshire, not just in terms of tackling health inequalities but also in terms of responding to the

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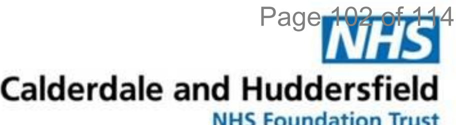

climate change emergency and economic recovery linked to the reconfiguration of hospital and community services.

We will continue to work closely with our partners on meeting the demands and requirements placed upon us by the Health and Care Bill if and when it comes into law. WY&H have had a good start in the Integrated Care System (ICS) partnership which has been in place for some time.

7. QUESTIONS AND ANSWERS

A number of questions had been submitted prior to the meeting.

Q: What is the Trust doing to reduce its carbon footprint, particularly in regards to any construction needed for reconfiguration, greenhouse anaesthetic gases and cross-site shuttle vehicles?
A: Stuart Sugarman responded

Reducing our operational carbon footprint
All hospital energy is now from 100% renewable sources
LED lighting system underway in both hospitals and generate savings of £216k per annum and is also reducing our energy usage and consumption
New ED design as part of reconfiguration will include a new air source heating pump
Over-cladding of buildings at HRI will be more thermally efficient and will reduce energy and heat and will keep them cool in summer
Carbon literacy training to be rolled out for colleagues to increase knowledge
Developing a Biodiversity action plan for hospital sites

Reducing the embodied carbon associated with construction
Have undertaken a building life cycle assessment and awaiting results which will address embodied carbon associated with the extraction of raw materials, construction, operational use and demolition and disposal
Developing a Sustainable Procurement Policy to limit material usage on the site

Anaesthetic gas consumption limit usage and seek alternatives
Engaged with pharmacy colleagues and promoting within the Trust to try and limit the use of an anaesthetic gas and looking at devices to capture the gas that is used.

Transport
New fleet of electric and hybrid vehicles and new hybrid shuttle buses are on order. As part of the reconfiguration work, we have developed a travel plan to increase cycling and walking to work. A park and ride service is also been developed for colleagues to allow colleagues to travel to work in a more sustainable way.

Calderdale and Kirklees Councils are developing a new cycle route which will link the two hospital sites.

The Trust Green Plan sets out the Trust's ambitious plans for climate sustainability over the next five years. The Trust also have a Green Planning Committee. If anybody is interested in joining this Committee, please contact Stuart Sugarman.

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More information can be found here: https://www.chs-limited.co.uk/our-green-plan-and-sustainability

Q: If and when the new A&E is built in Huddersfield, what will happen to the site vacated. Could it perhaps become a McMillan centre for the Trust, as vulnerable local cancer patients don't have to go out of the area.
A: Gary Boothby responded
A new build is being progressed to replace the ED at HRI rather than upgrade the existing area. This is because the current HRI which dates from the 1960s is in poor condition with maintenance backlog requirements. For this reason, it is unlikely that the area vacated would be suitable for a Macmillan centre.

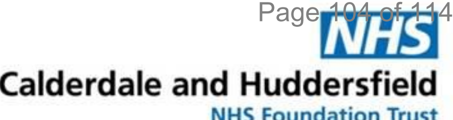
Q: Why are families of children with epilepsy who live in Huddersfield still having to travel to Calderdale for their epilepsy outpatient appointments? I have been informed this will still be the situation in August despite Acre Mill outpatients being opened for other paediatric specialities. Many of these children have additional complex needs, learning disabilities and mobility issues and their families have struggled to get to Calderdale even if they have transport, which not all do. I had understood the future planning was to continue to have outpatient services on both sites?
A: Helen Barker responded
We continue to operate in outpatients with restrictions as a consequence of Covid 19 and still have limited staff available within our outpatient services.
To maximise the capacity available to see patients we are continuing with the clinics in a single location but are constantly reviewing this as we look forward.
We recognise this is a challenge for some families and will be ensuring we work with them individually on ways to help with any access concerns.

Q: Any plans on improving urgent appointments for neurocare?
A: Helen Barker responded
Yes, we have several developments in relation to Neurology including working with Leeds where we have advertised for a joint appointment and are discussing with them a more formal partnership to maximise capacity. (real shortage of neurology consultants) In addition, we are working with our local commissioning partners to bring in some immediate capacity (as we are with some other specialities) to help reduce our backlogs and ensure access for urgent referrals.

Q: There is a Yorkshire-wide shortage of operating theatre staff. Until such time as it becomes possible to recruit more—and aside from an intention to prioritise patients who need non-emergency surgery for progressive conditions especially cancer - what other principles will guide the Trust in prioritising patients for planned surgery?
A: Helen Barker responded

We are doing a specific piece of work to become an employer of choice for surgical staff with one of the consultants working actively on a recruitment and retention plan.

The Trust is at the forefront of thinking around Health inequalities and is using this to guide its recovery. We have implemented a recovery plan that is based on this & clinical need. We have already made huge progress for patients with a learning disability with over 90% of those on the list having their procedure. We are prioritising patients who were listed as clinically urgent or should have had their



procedure within 3 months of listing as well as those who have waited over 104 weeks. We are now looking at other vulnerable groups for example homeless patients on our waiting list as well as ensuring there is equity of access particularly where there are patients who live in areas with higher deprivation or are of a different ethnicity. Our clinical colleagues have been really supportive of this health inequalities approach to recovery.

Q: Thank you to the Trust for supporting the creation of a new MND Care Coordinator who is making a huge difference to the care of those diagnosed in the condition in Calderdale and Huddersfield. How important is it to ensure pathways are coordinated across the community, hospital and palliative care and what more can be done to lock improvements in for the future?
A: Ellen Armistead responded
The Trust has been supported in setting up the post by the MND Association and the Nick Smith Foundation, and for this we are incredibly grateful.

Providing high quality care for those with life limiting illness is absolutely critical for both the patient and their loved ones. Those in our care should never have to be concerned with which organisation is providing care only that they receive care by the right person with the right skills at the right time. This is where the role of care coordinator can make such a difference. The coordinator's role is to manage the patient's journey and ensure that the input of all partners in care are managed and well organised.

Clinics are now in place and there is engagement and support from the multidisciplinary team to attend including dieticians, nutritional specialist nurses, dedicated respiratory physiotherapists, neurology consultant, palliative medicine consultant, community teams and a representative from Leeds ventilation service.

As well as people living with MND we have developed a number of care pathways that enable seamless transition especially where patients are moving toward end of life care. The Trust works closely with a range of partners and have clinicians in key posts working across acute and community settings.

The ambitions of the new healthcare reforms are to ensure that health and care services are planned as an integrated system that allows for seamless care delivery.

There were no additional questions raised at the meeting.

8. CLOSING STATEMENT

The Chair thanked everyone for attending and noted particular thanks to the speakers and the IT team for their support in the organisation of this virtual meeting.

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Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE –
REVIEW OF QUALITY AND PERFORMANCE REPORT - WORKFORCE

Held on Monday 7 June 2021, 3.45pm – 4.45pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
David Birkenhead	(DB)	Medical Director
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Helen Senior	(HS)	Staff Side Chair
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Anna Basford	(AB)	Director of Transformation and Partnerships (for agenda item 74/21)
Leigh-Anne Hardwick	(LAH)	HR Business Partner (for agenda item 70/21)
Nikki Hosty	(NH)	Assistant Director of HR (for agenda items 68/21, 75/21, 76/21)
Jackie Robinson	(JR)	Assistant Director of HR (Observing)
Karen Spencer	(KP)	Associate Director of Nursing (for agenda item 72/21)
Debbie Wolfe	(DW)	Head of Therapies (for agenda item 71/21)
Pam Wood	(PW)	Head of Apprenticeships and Vocational Training (for agenda item 76/21)

63/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

64/21 **APOLOGIES FOR ABSENCE**

Jason Eddleston, Deputy Director of Workforce & Organisational Development
Andrea McCourt, Company Secretary

65/21 **DECLARATION OF INTERESTS**

There were no declarations of interest.

66/21 **MINUTES OF MEETING HELD ON 7 JUNE 2021**

The minutes of the Workforce Committee held on 7 June 2021 were approved as a correct record.

67/21 **ACTION LOG – August 2021**

The action log, as at 9 August 2021, was received.

68/21 **MATTERS ARISING**

Workforce Committee Action Plan

The Committee agreed the action plan noting focus on the Committee's workplan to ensure corporate and divisional lead participation at meetings.

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OUTCOME: The Committee **AGREED** the action plan.

ED&I Recruitment Data and Action Plan

NH presented a paper that provided an analysis of recruitment activity to demonstrate ED&I data against the context of the local population. NH also presented the activities and forward actions to improve and strengthen inclusive recruitment. Key points include:-

- Pre sift values based recruitment questions developed plus a pool of EDI interview questions
- Building relationships within our communities through widening participation
- Inclusive recruitment panellist training
- Mandatory for all roles above band 6 to have an inclusive recruitment representative on the panel (from 1 October 2021)
- Inclusive recruitment representatives will play a key role in the decision making process
- Using feedback and data to identify areas of poorer practice through interview feedback loop
- Enhance focus on inclusive leadership and unconscious bias development
- Systematic review of recruitment documentation

KH asked about the language used in job descriptions to ensure inclusivity. NH confirmed end to end process reviews are in place that will take on board feedback from colleagues and communities once relationships further established.

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

69/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JULY 2021**

MB presented the report.

Performance on workforce metrics is now green and the Workforce domain at 76.1% in June 2021. This is the first month out of eight months previously 'where the domain score is 'Green'. 4 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)', and Data Security Awareness EST compliance. Medical appraisals are currently postponed due to the current Covid-19 pandemic.

Workforce – June 2021
The Staff in Post decreased by 14.89 FTE, which, is due, in part to 46.25 FTE leavers in June 2021. FTE in the Establishment figure increase by 40.41, along with student nurses leaving.

Turnover increased to 7.88% for the rolling 12 month period July 2020 to June 2021. This is a slight increase on the figure of 7.72% for May 2021.

Sickness absence – June 2021
Sickness absence reporting has been amended to be for the previous month compared to 2 months behind previously.

The in-month sickness absence increased to 4.81% in June 2021. The rolling 12 month rate also increased marginally for the twenty first consecutive time in 31 months, to 4.44%.

Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 35.95% of sickness absence in June 2021, increasing from 34.60% in May 2021.

The RTW completion rate decreased to 77.38% in June, down from 83.62% in May 2021.

Essential Safety Training – June 2021
Performance has increased in 8 of the core suite of essential safety training. With 10 out of 10 above the 90% target and 4 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance increased to 95.64% and following last month's decrease is the first increase for a month. It is now also above the stretch target of 95.00%.

Workforce Spend – June 2021
Agency spend increased to £0.61M, whilst bank spend decreased by £0.40M to £2.08M.

Recruitment – June 2021
4 of the 5 recruitment metrics reported (Vacancy approval to advert placement, pre employment to unconditional offer and unconditional offer to acceptance and Interview to conditional offer) deteriorated in June 2021. The time for Unconditional offer to Acceptance in June 2021 increased and was 3.0 days.

KH noted the increase in sickness absence and expressed concern at the main reason being stress/anxiety and suggested this is a bi-product of Covid and stress over a long period of time.

KH questioned the Trust's turnover rate of 7.8% against the target of 11.5%. MB explained the recording of turnover is being questioned as a leaver who remains on bank shows as continued employment in ESR and therefore not captured as a in the turnover figures. MB pointed out that this method of recording turnover data has been consistent for some time. The Committee noted the target of 11.5% was set some time ago when the Trust's turnover was greater than 12%.

KH confirmed the Committee will continue to monitor workforce data, in particular RTW compliance. KH was pleased to see an increase in the overall domain score.

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

70/21 **VACANCY DEEP DIVE**

LAH presented a paper that provided information about the current vacancy position, updates on hotspot areas and actions taken.

Due to COVID, workforce planning for 2020-21 was delayed until September 2021. Planned staff numbers and vacancy position for the remainder of 2020-21 was submitted to NHSE/I in our Phase 3 workforce plan. Further plans for quarter 1 and quarter 2 of 2021-2022 were submitted during May 2021 and formed part of the ICS planning submission to NHSE/I in June 2021. The Trust's vacancy position was planned to be at 326.71 fte in June 2021 and currently is at 184.75 fte. This difference is in part due to over recruitment of the Health Care Support Worker grouping during the push for a zero vacancy position in early 2021. In addition higher levels of temporary bank/agency usage predicted during planning did not translate to the actual budget set for 2021-2022.

The Trust turnover has increased from 7.06% in June 2020 to 7.93% at the end of June 2021. As referenced in the Workforce report item, this metric is being questioned in terms of those who leave but retain bank contracts and are not included in the turnover figures. In reality this will be higher than 7.93%.

Medical and Dental
In response to Covid and recovery the budgeted establishment for Consultants has increased from 276 wte in June 2020 to 293 wte in June 2021. Thirty vacant consultant level posts exist though 7 substantive and 13 locum consultants are to commence over the coming months.

An exercise is taking place to identify future retirement plans.

The roll out of new SAS contracts and the introduction of the Specialist role gives additional flexibility to look at how medical posts can be filled where Consultants are not available. Introduction of the Specialist role will not necessarily increase headcount, however, it may be an effective retention measure.

Nursing and Midwifery
In response to the review of workforce models, 4 rolling adverts for: Staff Nurse Medicine; Staff Nurse Surgery; Return to Practice Nurse; and Nursing Associate are in place, whilst maximising opportunities to attract the next cohort of new graduates in 2021.

An accelerated programme of International Recruitment has committed to supporting 70 International Nurses during 2021.

The Medical Division has reviewed baseline vacancy position against enhanced workforce models that were in place to support Covid. A number of colleagues have chosen to remain in the division following deployment which has improved the vacancy gap. Targeted recruitment continues in areas such as Respiratory as we move to delivering an ARCU (Acute Respiratory Care Unit) model to aid with recovery and sustainability to support our population with long Covid.

Surgical Division – colleagues have returned from deployed Covid support areas. There are 29 Operating Theatres vacancies (ODP and nurses) and a rolling advert for Endoscopy.

FSS - Following deployment and WFM reviews within Outpatients, recruitment activity has continued. A Practice Educator has been appointed to the team to support continued development and cross skilling of OP workforce across clinical and non-clinical colleagues. Rolling adverts continue for Midwives, the pandemic has seen a higher level of retention. The team continues to move towards new models of working as part of the better births agenda and continuity of carer. Recent funding as a result of the Ockenden report will support further recruitment activity which will be managed through LMS central recruitment. Rolling adverts are in place for Paediatrics over-recruitment is in place to enhance the workforce position.

Clinical
A strong Nursing Associate pipeline programme is progressing, 6 Cohorts are underway and recruitment to cohort 7 has commenced. 53 Nursing Associates have now registered and 38 Apprentice Nursing Associates remain in programme. Recruitment from the 2020/2021 3rd year student cohort is underway, with 63 students under offer, taking up employment Sept/Oct 2021.

The Medical Division continue to review the staffing in Cardio-Respiratory and have progressed a training structure to 'grow our own' physiologists. ICS and bank support is bridging the gap.

There have been a number of vacancies within the phlebotomy team. WTGR sessions have been held and recruitment activity is underway.

Following a meeting with the University of Huddersfield, an ODP Apprenticeship scheme is to commence for the future longer term plan. An Operating Theatres Workforce Transformation group has been established.

Admin & Clerical
Work around the ability to recognise digital efficiencies against administration time is on-going. Divisions regularly review all admin and clerical vacancies to identify current and planned recruitment to posts. The Committee noted FSS have completed a review of admin

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capacity, which will inform plans to realign PA support across the division and includes a review of medical secretaries' roles in line with current capacity constraints.

Healthcare Scientists, Therapeutic and Technical
The vacancy gap for qualified Bio Medical Scientist roles has reduced however the WYATT hub and spoke work may affect the ability to recruit and retain staff into the future. Engagement sessions have commenced. Over recruitment to Radiographer roles, has proven successful in the past and supports the throughput of colleagues wishing to specialise in MRI/CT. There have been several vacancies within the pharmacy team, some as a result of service growth such as Homecare. These are closely monitored by the team and recruitment activity is on-going.

KH noted the volume of work taking place and in particular the success of the international recruitment campaign.

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

71/21 **DEEP DIVE - ALLIED HEALTH PROFESSIONALS (AHP) RECRUITMENT AND VACANCY POSITION**

DW presented a detailed report into the recruitment and vacancy position of AHPs. The Committee noted there is regular turnover in Physiotherapy and Occupational Therapy. This is mitigated by over recruiting to Band 5 vacancies on a yearly basis. Currently there is not a national shortage of AHPs affecting our ability to employ staff, however there is recognition a shortage is anticipated in the coming years.

Vacancy trajectory is based on the Phase 3 workforce plan for September 2020 to March 21 and the annual planning submission for Q1-Q2 2021-22 submitted to NHSE/I, this shows the AHP vacancy position was planned to be at 8.24 fte in June 2021 and currently is over established at -3.74 fte.

Sickness absence rates had remained static, now increasing specifically in relation to stress and anxiety. Line managers continue to receive support from HR colleagues to manage absence. Specific attention is placed on reminding line managers of the importance of recording RTW Interviews.

Colleagues have their health and wellbeing hour rostered. Head of Therapies allocates an hour each week for colleagues to book dedicated time to discuss issues that are impacting on their working or home lives.

AHP turnover has increased from 7.88% in June 2020 to 10.15% at the end of June 2021. Newly qualified Physiotherapists and Occupational Therapists join the Trust in June/July. A continuous recruitment approach to these two specialities is undertaken as band 5 colleagues leave the Trust in pursuit of band 6 opportunities.

DW highlighted the difficulty to recruit and retain band 6 colleagues from all professions. Bands 7 and 8 often pursue work in the private sector. Nationally speech and language therapists are on a shortage list, however Huddersfield University is to commence speech and language training in September 2021.

HS raised a concern that physiotherapists were not allowed to work as flexibly as other therapy colleagues. DW said the Flexible Working Policy is applied equally and wasn't aware of any issues. DW would pick up the issue outside of the meeting.

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HS asked if following the exit questionnaire if a theme had emerged as to why colleagues are leaving. DW hadn't perceived there was a theme. DW added that she writes separately to colleagues once left requesting feedback however response is poor.

HS asked about physiotherapists who work in Frailty within Medicine Division as she is aware of issues of colleagues working in different areas whose role is different to a standard physiotherapist job description. DW confirmed these colleagues do not sit within her remit but would ensure she connects with such colleagues. JR asked that details of specific issues are shared with the HRBP and General manager.

DS wanted to know more about the challenges to band 6 recruitment. DW explained a significant reason is band 5 high turnover means colleagues are not getting the experience (minimum 2 years to experience different rotations, grow in confidence) to put them in a position to apply for a band 6 post. Additionally, there is competition with larger hospitals, primary care and local authority, and colleagues who are leaving the profession completely.

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

72/21 **DEEP DIVE - MATERNITY SPECIFIC ESSENTIAL SAFETY TRAINING (EST)**

KS advised that colleagues working within maternity services undertake a suite of role specific essential safety training to meet the health promotion aspects of midwifery care and also the regulatory requirements for maternity services. Much of this training is either delivered face to face via 2 mandatory training days or hosted via external on-line platforms such as e-learning for health.

Training compliance is recorded on ESR which requires both the training requirement and compliance to be manually inputted into ESR. Maternity services have recently appointed a Practice Educator who has reviewed each midwife's training requirement and compliance within ESR to ensure accurate information is held within ESR. KS highlighted an issue concerning ESR position numbers. JR advised this would be picked up outside of the meeting.

A monthly review of role specific safety training is undertaken at the confirm and challenge meetings attended by maternity matrons and ward managers and role specific training review will be included in the annual staff appraisal. The maternity role specific training needs analysis (TNA) developed a training needs matrix for all permanent and bank midwives, maternity staff members, and medical staff in training

As an output of the Ockenden review the Local Maternity System (LMS) has produced a core competency framework for midwives which will ensure parity with role specific safety training across the LMS. The CHFT maternity services role specific EST guideline and TNA will be updated in line with the core competency framework.

All midwifery managers have been provided with the current compliance reports for their clinical areas with an expectation that role specific safety training is reviewed as part of the annual staff appraisal. Role specific training for maternity services is reviewed monthly within the weekly confirm and challenge meetings attended by Matrons and Ward Managers.

Maternity Role Specific EST is via e-learning and two classroom based study days. In addition staff are allocated 10 hours to complete the remaining elements of EST. Unfortunately neither the on line or face to face classroom based training is linked to ESR leading to significant delays in capturing accurate data.

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The report asks the Workforce Committee to support a proposal that maternity ward and department managers undertake the necessary training to be able to add training compliance to ESR.

OUTCOME: The Committee **NOTED** the report and **SUPPORTED** the roll out of training for maternity ward and department managers to allow them to add training compliance to ESR.

73/21 **REVALIDATION AND APPRAISAL ON NON-TRAINING GRADE MEDICAL STAFF 2020/2021**

DB confirmed that as a result of COVID-19 the appraisal process was suspended by NHSE on 19 March 2020. The process was restarted on 1 October 2020 using a temporary revised appraisal format, however the need to complete an appraisal was not mandated. The GMC also suspended for 12 months revalidation recommendations due between 17th March 2020 and 31st March 2021. The Committee noted an annual report wasn't produced this year because of the suspension, however this paper outlined the Trust's management of medical appraisal and revalidation. DB highlighted that appraisals did continue on a voluntary basis with 40 colleagues requesting an appraisal. Focus on health and wellbeing was included in the appraisal conversation. DB confirmed the appraisal process has now formally re-started.

KH asked about deferrals. DB advised deferrals are in relation to revalidation which due to the suspension were not relevant during that time.

OUTCOME: The Committee **NOTED** the report and had assurance that the agreed processes for GMC revalidation and appraisal including the temporary revisions in light of COVID-19, have been adhered to.

74/21 **BUSINESS BETTER THAN USUAL (BBTU)**

AB presented an update on the progress made against the BBTU engagement themes from April 2021 to June 2021. Of the 12 engagement themes 5 are amber and 7 green.

KH asked about the amber rated themes. AB highlighted the positive actions around theatre productivity acknowledging there was more work to do. WOD are supporting engagement and improvement work. AB confirmed digital visiting is a massive success story, work is progressing to ensure we have the right workforce resources to continue. HS raised a concern regarding the impact on pathology laboratory services as phlebotomy capacity increases. AB took this board and thanked HS for raising the implication.

DS asked if working from home principles had been agreed. AB confirmed currently the message in the Trust is to continue working as you are and to complete risk assessments. AB outlined the work undertaken so far and prior to formulating principles next steps include mapping accommodation, colleague survey, drop-ins and 1:1s.

OUTCOME: The Committee **NOTED** the progress in the Business Better than Usual programme of work.

75/21 **FREEDOM TO SPEAK UP (FTSU) BOARD SELF ASSESSMENT**

- NH presented a report that provided a summary of the responses submitted by individual members of the Board of Directors to a questionnaire based on an NHS England/NHS Improvement (NHSE/I) Freedom to Speak Up (FTSU) self-assessment tool designed specifically for NHS Boards to use to assess progress in the development of a positive freedom to speak up culture. A full report with recommendations for action will be presented at the Board of Directors public meeting on 4 November 2021. Engagement with colleagues through our equality network groups and beyond will take place from November 2021.

KH felt some of the questions were not easy to answer however the report was a good summary with points to take forward. NH suggested a piece on the national FTSU Guardian could be included into annual reports.

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

76/21 **PROGRESS UPDATE ON WORKFORCE STRATEGIES**

Equality, Diversity & Inclusion

NH updated the Committee on the progress of the ED&I strategy, the highlights included a significant growth in the number of networks, which now totalled 8 with a further 2 in the pipeline. NH described activity with a Community focus included the new BAME Community Engagement Advisor, establishment of a Widening Participation Team, a Conscious Youth Partnership, EDS2, Windrush Day, Pride Month and Happy Valley Pride. Tailored wellbeing packages to support individual colleagues were put in place along with support for colleagues affected by the Covid pandemic in India. Leadership development and talent succession focusses around inclusive, equality discussions with one culture of care and health and wellbeing at the heart of the conversation. An enhanced talent development programme is underway and 25 colleagues to graduate from the Empower Programme.

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

Leadership Development

NH shared the outcome of a review of the Leadership Development platform. 1301 colleagues had enrolled onto the programme. Pandemic impact on workload hugely affected colleagues' opportunity for development. Along with the review results NH detailed proposed enhancements to complement the current digital learning. A blended approach will be introduced to include action learning groups, workshops, reflective practice, coaching and mentoring. It is anticipated the refreshed programme would commence at the end of September with a range comms and engagement starting mid-August.

DS asked if colleagues would have support of managers to get involved in project work. NH is optimistic that managers will embrace the benefits of an inclusive leadership focus to the benefit of improving our leaders.

OUTCOME: The Committee **NOTED** the progress update.

Apprenticeships

The presentation had been shared with the Committee ahead of the meeting. The pandemic had a significant impact on new apprentice starts, timely completions and levy utilisation. A number of challenges remain for 2021/2022 and the Committee is asked to support the targets to tackle barriers as outlined in the presentation.

PW is delighted the team achieved an overall effectiveness of 'Good' in the July 2021 Ofsted inspection of the Trust's in-house deliver of Healthcare Support Worker level 2 apprenticeship. Four of the 5 elements were graded 'Good' with the fifth, Behaviour and Attitudes graded 'Outstanding'. KH congratulated PW and her team and SD added this is a testament to their hard work.

OUTCOME: The Committee **NOTED** the update presentation and **SUPPORTED** the 2021/2022 targets.

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77/21 **PROGRESS ON STAFF SURVEY ACTION PLANS**

SD confirmed the Board of Directors received an update at it July meeting and divisional progress is monitored at performance review meetings. The Trust-wide action plan is overseen by WOD. SD acknowledged the tough time colleagues are facing and stressed the importance of the wellbeing agenda. The Committee noted the Community Division is utilising the wellbeing hour, other progress has been made with targeted support. Increased visibility and walkarounds to include weekends are taking place. SD stated the Health and Wellbeing Strategy and One Culture of Care being the crux of everything we do. SD would circulate the updated action plans.

SD commented the next Staff Survey would likely be a challenge given the recent pressures. KH noted the Pulse Surveys too.

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

78/21 **BOARD ASSURANCE FRAMEWORK – DEEP DIVE MEDICAL WORKFORCE RISK**

DB presented a paper providing a deep dive into BAF risk10a/19 – Medical staffing

The Trust response to the pandemic has impacted on the pace of progression of some of the risk mitigation and the current risk score has been amended to reflect this. Despite the pandemic the Trust has been able to maintain recruitment and safe medical staffing levels in response to the Covid peaks. The Workforce Programme Steering Group will continue to monitor this.

The paper identified gaps in controls which included risk of pensions issue impacting on discretionary activity, national shortage in certain medical specialties, regional re-organisation that could potentially de-stabilise the workforce, E-rostering partially implemented for doctors, measure to quantify how staffing gaps increase clinical risk for patients and impact of Covid pandemic.

DB highlighted the work and activities to mitigate these risks:-

- Progress of key work streams – Flexible workforce, ACDP Bank and Agency, Recruitment and retention
- Alternative workforce models / roles
- Succession planning
- E job planning and e-roster paused but now re-started

KH and DS agreed the paper provided a comprehensive deep dive and acknowledged the enormous amount of work and progress in the last 12 months. DB commended Pauline North (Medical HR Manager) and Sree Tumula (Associate Medical Director) for their leadership and involvement in the medical workforce agenda.

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

79/21 **NON-EXECUTIVE DIRECTOR MATTERS**

KH presented a report that noted the decision regarding use of Non-Executive time and plans to pilot the role of an Associate Non-Executive Director. On completing an exercise earlier in the year, it was identified that Non-Executive Director (NED) workload significantly exceeded time available. The Chair and NEDs reviewed this position and proposed that NEDs should cease their involvement in chairing Consultant appointment panels. As a Foundation Trust, CHFT is not obliged to abide by the Consultant Appointment Regulations, however to date CHFT has broadly maintained the approach set out in the guidance described in the report. The Chair discussed the time pressures with the Director of Workforce and Organisational

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Development and it was agreed NEDs can be released from the commitment to Chair and attend AAC panels. This will be effective from September 2021 once the Workforce Committee and Board have been notified of this change.

NHS England / Improvement has carried out a review of NED roles and it is expected that national guidance will be issued in 2022 when engagement work and sampling of the new approach has been completed.

The report also described the role of an Associate Non-Executive Director. The Trust is planning to advertise for an Associate NED in the autumn, to focus on supporting the quality governance agenda. This will initially be a 12 month role. A CHS Associate NED to strengthen the CHS Board will also be recruited. The proposed recruitment process for the Associate Non-Executive Director roles will be presented to the Nominations and Remuneration Committee of the Council of Governors on 9 August for review and approval in line with the Trust's Constitution.

OUTCOME: The Committee **NOTED** the decision for Non-Executive Directors to no longer chair and attend AAC panels from 3 September 2021 and **NOTED** plans to pilot an Associate Non-Executive Director role.

80/21 **WORKFORCE COMMITTEE WORKPLAN**

The workplan was received and reviewed.

81/21 **ANY OTHER BUSINESS**

No other business was discussed.

82/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Assurance provided to Committee by way of deep dives
Apprenticeships success story
FTSU Self-Assessment
EDI and Leadership Development Programme

83/21 **EVALUATION OF MEETING**

KH thanked authors/presenters for high quality deep dive reports.
Good attendance - powerful to hear from divisional colleagues

84/21 **DATE AND TIME OF NEXT MEETING:**

30 September 2021:
1.00pm – 3.00pm - Hot House Inclusion and Health Inequalities
3.15pm – 4.15pm, Review Quality & Performance Report (Workforce)

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