Public Board of Directors 4 March 2021

Description	The following items are for Board Assurance
Organiser	Jacqueline Ryden

Documents for Review

1. Quality Committee Terms of Reference

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday, 4 March 2021
Meeting:	Board of Directors
Title of report:	Quality Committee Terms of Reference
Authors:	Doriann Bailey - Assistant Director of Patient Safety
Sponsor:	Ellen Armistead, Executive Director of Nursing
Previous Forums:	Quality Committee – January 2021

Purpose of the Report

A summary of the changes made to the Quality Committee terms of reference at the January 2021 Quality Committee meeting.

Key Points to Note

The amendment made to the Quality Committee terms of reference (v5) include:

- The following role has been added to the membership to attend all meetings of the Committee:
  - Assistant Director for Patient Experience.

Recommendation

The Board of Directors are asked to note the updated terms of reference for the Quality Committee.

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1. The Trust Board hereby resolves to establish a Committee to be known as the Quality Committee. The Quality Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

2. Authority

2.1. The Quality Committee is constituted as a Standing Committee of the Trust Board. Its constitution and terms of reference are subject to amendment by the Trust Board

2.2. The Committee derives its power from the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4. The Committee is authorised by the Trust Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1. The purpose of the Quality Committee is:

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

3.2. The Quality Committee is responsible for:

- Reviewing proposed quality improvement priorities and monitoring performance and improvement against the Trust's quality priorities and the implementation of the Quality Account.
- Seeking assurance in the implementation of action plans to address shortcomings in the quality of services should they be identified.
- The ongoing monitoring of compliance with national quality standards and local requirements.

4. Duties

The duties of the Committee, given below, cover quality improvement, governance and risk, quality and safety reporting and audit and assurance.

Quality improvement

4.1. To review proposed quality improvement priorities and monitor progress and compliance against defined quality priorities.

4.2. To maintain a focus on patient experience through a number of data sources including stories; friends and family test; national surveys and seek assurance that the Trust is learning from experience.

4.3. To oversee the development of the Quality Accounts to ensure accuracy of data and compliance with timescales for publication and review progress against these.

4.4. To review the Trust's compliance with the Care Quality Commission essential standards of quality and safety and seek assurance regarding progress with action plans in response to quality concerns identified from inspection findings, warning notices and compliance actions.

4.5. To receive, through the reporting schedule, assurance of high quality care provision and compliance with national and local guidelines, standards and requirements.

4.6. To establish, develop and maintain systems and processes for the regular evaluation and monitoring of compliance against any relevant internal and external assessments, standards or criteria.

Governance and risk

4.7. Ensure all quality risks are appropriately managed across the Trust and that appropriate review and assurance mechanisms are in place, receiving and reviewing quality risks on the high-level risk register and Board Assurance Framework

4.8. Promote a just and open culture in which incident and risk reporting is encouraged and supported as part of the delivery of safe and effective healthcare.

4.9. Seek assurance on the process for reviewing and reporting incidents and serious incidents and sharing the learning from these.

4.10. Seek assurance against compliance with NICE guidelines / guidance and any rationale for non or partial compliance

4.11. Seek assurance that there are effective systems of governance, performance and internal control in relation to clinical services, research and development through an annual governance review.

4.12. Review performance against the quality and safety aspects of the Integrated Performance Report

4.13. Undertake an annual review of the quality impact assessment process to gain assurance that the risks to any impact on quality arising from proposed cost improvements have been managed and mitigated.

4.14. Ensure any procedural, policy or strategy documents which fall within the remit of the Committee are appropriately written, ratified and monitored for compliance in accordance with the Policy for Development and Management of Procedural Documents (Policy for Policies) and any key national standards and best practice

4.15. Receive a quarterly report from each of the sub-groups to the Committee.

4.16. Establish an annual work plan which the Committee will review quarterly

4.17. Produce an annual report against delivery of the terms of reference of the Quality Committee.

Quality and safety reporting

4.18. In accordance with the Committee reporting schedule, receive assurance from the Committee's sub-groups, review reports and any associated recommendations, including actions to gain assurance of compliance and quality improvement.

Audit and assurance

4.19. To approve and oversee delivery of the clinical audit plan and a review of its findings.

4.20. To receive all reports regarding the Trust produced by the Care Quality Commission and other external bodies, e.g. Royal Colleges, and seek assurance on the delivery of actions to address recommendations

4.21. Receive reports from invited service reviews and external visits (as appropriate) and seek assurance regarding delivery of actions

4.22. To receive reports on significant concerns or adverse findings highlighted by external bodies in relation to quality and safety and the actions being taken to address these.

4.23. Gain assurance from divisions that they implement the activity required to achieve compliance with service quality and governance standards.

4.24. To receive internal audit reports (with a quality element) and seek assurance on recommendations

5. Membership and attendance (11)

5.1. The Committee shall consist of the following members:

- Two Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Executive Director of Nursing
- Medical Director
- Deputy Director of Workforce and Organisational Development

5.2. The following shall be required to attend all meetings of the Committee:

- Assistant Director of Patient Safety
- Assistant Director of Patient Experience
- Deputy Director of Nursing
- Clinical Director of Pharmacy / Trust Controlled Drug Accountable Officer
- Head of Risk
- Governance administrator (notes)

5.3. The Chair of the Board of Directors will appoint a representative of the Council of Governors to attend each meeting as an observer. The appointment will be reviewed each year.

5.4. The following shall be required to attend the meetings focused on divisional performance (one meeting per quarter):

- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Surgery & Anaesthetics
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Medicine Division
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Families and Specialist Services
- Divisional Director **OR** Director of Operations **OR** Associate Director of Nursing - Community Division

5.5. Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.6. A quorum will be four members of the Committee and must include at least three board members of which one must be a Non-Executive and one an Executive Director.

5.7. Attendance is required at 75% of meetings. Members unable to attend should indicate in writing to the Committee Administrator of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.8. A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1. The Committee shall be supported by the Administrator, whose duties in this respect will include:

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation
- Maintaining a record of attendance.

7. Frequency of meetings

7.1. The Committee will meet every month and at least nine times per year.

8. Reporting

8.1. The Committee Administrator will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2. An action schedule will be articulated to members following each meeting and must be duly completed and returned to the Administrator for circulation with the agenda and associated papers.

8.3. The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4. Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next Trust Board of Directors meeting.

8.5. A summary report will be presented to the next Trust Board meeting.

9. Review

9.1. As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2. The terms of reference of the Committee shall be reviewed by the Trust Board of Directors at least annually.

10. Monitoring effectiveness

10.1. In order that the Committee can be assured that it is operating at maximum effectiveness in discharging its responsibilities as set out in these terms of reference and, if necessary, to recommend any changes to the Senior Management Team, the Chair will ensure that once a year a review of the following is undertaken and reported to the next meeting of the Committee:

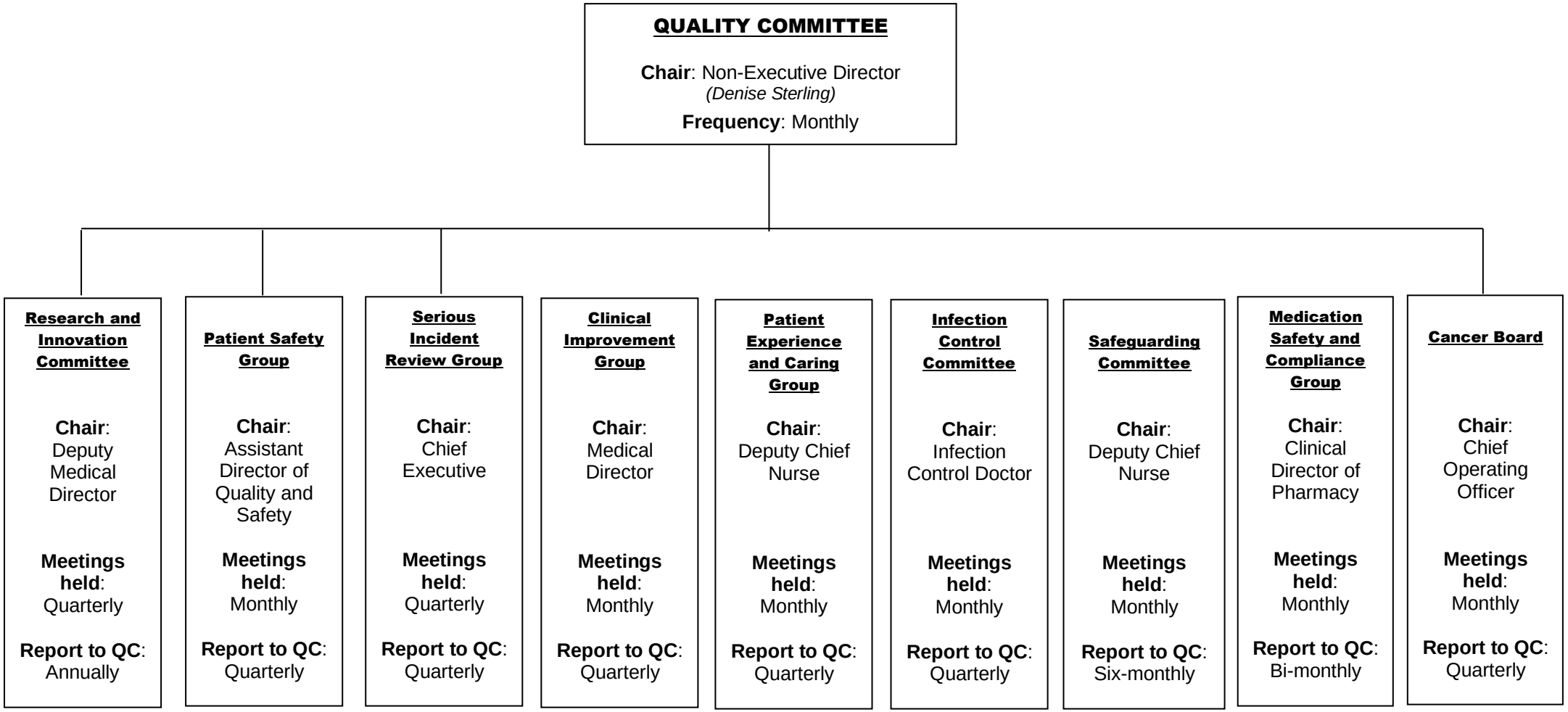
- The objectives set out in section 3 were fulfilled;
- Members attendance was achieved 75% of the time;
- Agenda and associated papers were distributed 5 working days prior to the meetings;
- The action point from each meeting are circulated within two working days, on 80% of occasions

Appendix 1
Members and required attendees of the Committee

Title	Required at
Non-Executive Director ***(Chair)***	All meetings
Non-Executive Director ***(Vice Chair)***	All meetings
Executive Director of Nursing	All meetings
Medical Director	All meetings
Deputy Director of Workforce & Organisational Development	All meetings
Assistant Director of Patient Safety	All meetings
Assistant Director of Patient Experience	All meetings
Deputy Director of Nursing - Corporate	All meetings
Clinical Director of Pharmacy / Trust Controlled Drug Accountable Officer	All meetings
Head of Risk	All meetings
Council of Governors	All meetings
Governance Administrator ***(Minutes)***	All meetings

Quarterly Representation	Required at
Surgical Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
FSS Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
Medical Division Divisional Director / Director of Operations / Associate Director of Nursing	Quarterly meetings
Community Division Director of Operations / Associate Director of Nursing	Quarterly meetings

Appendix 2
Sub-Groups



Appendix 3
Reports aligned to CQC domains

CQC domain	Reporting to Quality Committee via
Safe	▪ Safeguarding (Six monthly and annual reports) ▪ Patient Safety Group (Quarterly) ▪ High Level risk register (Bi-monthly) ▪ Medication Safety and Compliance Group (Bi-monthly) ▪ Serious Incident Report (Monthly) As required: ▪ Prevention of future death reports, ▪ Incident reports / action plans.
Effective	▪ NICE guidance compliance (Annual) ▪ Clinical Improvement Group (Quarterly) ▪ Cancer Board Report (Quarterly) As required: ▪ Service specific reports / invited service reviews as required – detailed in workplan
Experience	▪ Patient Experience and Caring Group (Quarterly)
Responsive	▪ Quarterly report (Quarterly) ▪ Quality Account (Quarterly) ▪ Quality Annual report
Well-Led	▪ CQC report (Six monthly) ▪ Research and Innovation (Annual) ▪ Quality Impact Assessment process (Annual) ▪ Divisional Patient Safety and Quality Board Reports (Quarterly) ▪ Serious Incident Review Group (Quarterly) ▪ Infection Control Committee minutes (Quarterly)
Overall	▪ Quality Performance Report (Monthly)

Version Control	
1.1	first draft circulated for review to Chair / Director of Nursing
1.2	Amendments prior to Trust Board
1.3	Amendments after submission to Quality Committee
1.4	Further amendments
1.5	Further amendments
2	Amendments made: ▪ Director of Workforce and Organisational Development added to section 5.1; ▪ Section 5.2 added ▪ Divisional attendance amended in section 5.4 ▪ Quorum amended at section 5.6 ▪ Medication and Safety Compliance Group and Cancer Board added to sub-groups at appendix 2 ▪ Medication and Safety Compliance Group and Cancer Board added to reports at appendix 3
3	Amendments made: ▪ Chief Operating Officer removed from membership ▪ Executive Director of Planning, Estates and Facilities removed from membership ▪ Two non-executive directors instead of three ▪ Purpose added in relation to internal audits
3.1	Amendments made (with Chair) (June 2019) ▪ Organ Donation Committee and Cancer Board added to sub-groups at appendix 2 ▪ Frequency of sub-group meetings amended at appendix 2 ▪ Frequency of meetings amended at appendix 3
4	Amendments made (Jan 2020) ▪ Organ Donation Committee removed from sub-groups at appendix 2 ▪ Addition of named NED at appendix 2 ▪ Frequency of Medication Safety and Compliance Group changed from quarterly to monthly at appendix 2 and 3
4.1	Amendments made (June 2020) ▪ Clinical Director of Pharmacy added to membership ▪ Executive Director of Workforce and Organisational Development amended to Deputy Director of Workforce and Organisational Development
5	Amendment made (January 2021) ▪ Assistant Director of Patient Experience added to membership

Appendices	**1.** List of members **2.** Subgroups **3.** Reports aligned to CQC domains
Issued by Quality Committee	January 2021
Due for Review	January 2022
Approved by Board of Directors	TBC

2. Update from sub-committees and receipt of minutes and papers

- Finance and Performance Committee meetings held 11.01.21 and 01.02.21
- Quality Committee meetings held 30.12.20 and 25.01.21
- Workforce Committee meetings held 08.02.21
- Covid-19 Oversight Committee held 26.01.21
- Audit and Risk Committee meeting held 26.01.21
- Council of Governors meeting held 28.01.21

Calderdale and Huddersfield NHS Foundation Trust

APP A

Minutes of the Finance & Performance Committee held on
Monday 11 January 2021, 11.00am – 1.45pm
Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Minutes)
Kirsty Archer	Deputy Director of Finance
Lindsay Rudge	Deputy Director of Nursing and Infection Prevention and Control
Peter Keogh	Assistant Director of Performance
Stephen Baines	Governor representative
Stuart Baron	Associate Director of Finance

ITEM

001/21 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

The Chair also noted his concerns regarding the late arrival of a number of papers accepting the unprecedented circumstances but stressing the need to avoid a recurrence.

002/21 APOLOGIES FOR ABSENCE

There were no apologies to note.

003/21 DECLARATIONS OF INTEREST

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

004/21 MINUTES OF THE MEETING HELD 30 NOVEMBER 2020

The Minutes of the Public meeting were APPROVED as an accurate record subject to the following amends: -

Agenda items 155/20 and 159/20 – the word 'good' should be removed to read "IPR - overall performance at October was at 70%."

The Minutes of the Private meeting held 30 November 2020 were also APPROVED as an accurate record.

005/21 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed as follows:

115/20: Business Better Than Usual (BBTU) – The Director of Transformation & Partnerships updated the Committee that a detailed report showing the progress

being made around the delivery programme will be shared with Finance & Performance Committee at the next meeting – **AB, 1/2/21**

149/20: Community Stroke model – The Chief Operating Officer reported that the Community element of Stroke is part of the recovery work in terms of 'Phase 4' which will be built into the annual planning process over the next few months.

153/20: NHSI Benchmarking – For context the Chair explained that a paper had been presented to Committee which identified potential savings opportunities which came out of the benchmarking process. The Chair questioned whether we had been assured that we had explored all the opportunities and how this can be concluded. The Director of Finance commented that we still need to agree how this can be pulled together, although it was noted that this could be included in the 2021/22 Planning process.

The Director of Finance confirmed that CIP for next year will be discussed with Divisional Directors this week to try to identify how we frame the future finance challenges/opportunities. It was noted that CIP will be re-branded and that meetings this week will try to find a way to engage with clinical colleagues – **Post meeting note –** the CIP process will be discussed and progressed outside F&P

009/21: Use of Resources (UOR) External Review – The Director of Finance explained that this item had been an on-going action and that the Committee had asked for an external review. It was noted that a request to under-go a 'mock assessment' had been made to NHSI/E and that their response was that this would have limited value and that capacity is not currently available. It was also noted that a similar request had been made to WYAAT who had provided the same response. The Director of Finance reported on the positive internal work which had been undertaken and with no robust data available at the moment questioned what an external review would look like. Following discussions with other DoFs it was agreed that a review of our governance around some of the decisions taken could be useful. GB, therefore, proposed to undertake a review of some of our governance to provide assurance to the Finance & Performance Committee.

The Committee discussed the view of whether this would be 'marking our own homework'. It was also highlighted that with the latest COVID lockdown and the focus nationally, the new financial regime in April 2021 is likely to be deferred. The idea that the UoR assessment as it stands may not be relevant going forward, in light of planned changes to the ICS role and commissioning arrangements, was also raised. It was also noted that our fiscal position is better than it was when the initial UoR assurance was undertaken in 2018.

The Chair acknowledged the various comments regarding the changes to the finance regime and that the position 2 years ago is going to be different going forward. However, the Committee has an obligation to assess the progress made since the 'Requires Improvement' rating in 2018 and as a minimum would require a further update on the feedback on the working groups, with a re-assessment of our latest financial position against the original assessment. It was noted that when a clearer picture is available a decision can be made as to whether we need an external view in the future.

ACTION: To provide the Committee with a brief paper summarising the scope, process, involvement, and the timescales of the review to enable the Committee to decide when the time would be right to produce this and discuss further – **GB/KA, 1/2/21**

138/20: Stroke Timelines - The Assistant Director of Performance provided an update to the Committee regarding the timelines which were requested against the actions outlined within the paper discussed at the Finance & Performance Committee in November. It was noted that the only key recommendation not to have been implemented due to the current bed pressures was the protection of beds. It was also noted that recommendations 5 and 7 have been implemented and are discussed at the Daily Tactical meeting.

The Committee acknowledged the action plan and timescales and that several of the recommendations have been implemented.

ACTION: To review improvement of the Stroke Indicators at Finance & Performance Committee again later in the year – **PK/HB, 4/10/21**

156/20: BAF Risks – The Director of Finance apologised for the late arrival of papers which will be discussed at Audit & Risk Committee on the 26 January 2021. The following actions were noted: -

- BAF risks 14/19, 15/19 and 18/19 have been updated to reflect the comments at the last meeting regarding the Capital score.
- The action to align the target score of risks 18 and 14 has been completed as part of the update process.
- Directors are currently reviewing all risks (including the allocation) therefore the question of which Committee will be reviewing the COVID risk is part of the update process.

The Committee **APPROVED** the updates of the Finance Risks on the BAF.

The Company Secretary explained that the sequencing of Committees is slightly out of order and that the following is the latest position: -

Risk 8/19 – is in the process of being updated.
Risk 9/19 – this risk has been reviewed in detail by GB and Stuart Sugarman and it has been agreed not to change the risk description but there will be a routine update.

The Chair asked for it to be made clear, when reporting to Audit & Risk Committee and Board, that F&P have not reviewed Risk 8/19 in detail.

Matters Arising
The Chief Executive asked for an update regarding the significant number of 12-hour trolley breaches within October and November.

The Chief Operating Officer commented that a paper will be going to Quality Committee at the end of January in relation to the 'harm' element.

The Director of Transformation & Partnerships provided an overview in terms of process and the role of the Outer Core group. It was noted that it had been recognised, prior to Christmas, that there had been a total of 58 12-hour breaches in waiting time within ED, and the Outer Core group requested a detailed report from the Incident Management Team (IMT). A report was prepared which detailed the work undertaken around the processes at that time and a view of the decision making that had occurred. It also detailed work undertaken to develop a standard operating procedure and training to be provided to all on-call consultants, managers, and directors. Following receipt of the initial response by the Outer Core group they went back for further clarification around the rationale used in the decision making around the risk assessment in terms of patients remaining in ED as opposed to utilising additional bed capacity on wards. The conclusion was that with the greater stability of the workforce within ED, on balance, it seemed a lower risk for patients to remain on beds (not trollies) within ED. Further clarification was also given around the planned training going forward. It was also noted that the reports have also been reviewed by the Oversight Committee who requested further detail to be presented to the Quality Committee, as above.

The Outer Core group subsequently had further discussions and asked for clarification that of the 58 incidents how many investigations have completed and what assessment of harm has been concluded in addition to key learnings.

In terms of assurance for the Finance & Performance Committee, it was noted that there has been a considerable amount of governance and assurance provided at a very difficult time operationally.

The Committee acknowledged the amount of time and effort put into the investigations around the decision making and the reasons for the actions, any further incidents will be picked up through the IPR where the Finance & Performance have visibility. Regarding the 58 incidents, the Committee agreed that they are comfortable for those to be picked up through the Quality Committee and Board.

ACTION: To provide the report going to Quality Committee on the 25 January 2021 along with the outcome of their discussions following that meeting for information to this Committee – **HB/BS, 1/3/21**

150/20: Diagnostic variances – The Deputy Director of Finance confirmed that it was an error in the description of the Re-set Plan, the Plan was understated and did not include all the elements so, therefore, there was a mis-match between the Plan and the actual and the Plan has since been rectified.

FINANCE & PERFORMANCE

006/21 INTEGRATED PERFORMANCE REVIEW – NOVEMBER 2020

The Assistant Director of Operations reported that the Trust's performance for November 2020 was 65.7% showing some deterioration in month. The following key points were highlighted: -

- SHMI has just gone above 100 for the last 12 months, this is being looked at with the Mortality Review Group
- 3 out of 4 stroke targets have been missed.

- For the first time we have been unable to reschedule an Outpatient appointment within 28 days due to the second Covid outbreak.
- We have seen further 12-hour trolley waits in month (included in the 58 referred to above) although processes have been put in place to resolve this issue.
- Long-term sickness absence has now tipped into Red with a peak of 2.77% for the last 12 months.
- Diagnostics 6-week waits have continued to improve.

It was also noted that final Appraisal results are due and there is a potential that this may go into an AMBER position.

In terms of the 38-day referral to tertiary it was noted that we are reliant on other organisations and their capacity.

With regard to Complaints, this is still an issue, however, there is more focus with the new members of the team who are working to progress complaints in a timely manner and we hope to see some improvements over the next few months. It was added that the Complaints Improvement Group, Chaired by Andy Nelson, Non-Executive Director will monitor those improvements.

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

007/21 PATIENT BACKLOG UPDATE

The Chief Operating Officer highlighted the themes of the presentation as follows: -

<u>New Referrals</u>

CHFT closed to referrals for a short period of time during April/May. We made a system decision to open (earlier than other Trusts) due to the concern of patients being 'lost' across the system which allowed us to understand the true nature of any backlog. This will have an impact on overall waiting numbers and potentially on the number of 52week waits. Overall referrals have not returned to pre COVID levels, this will be a mixture of reduced attendance at GPs, new pathways and other pathway redesign. For example, increased use of Advice and Guidance (A&G). These requests have doubled in 2020 compared to previous years.

Appointment Slot Issues (ASIs) is not in a good place due to the fact that we are accepting referrals, however, they are not being booked in directly but are going through several of the clinical assessment services. A slide showing some of the specialties where we have more of a concern than others was highlighted as an example.

The Chief Executive asked if the GP leadership looking at this information would recognise and be supportive of it? The Director of Transformation & Partnership confirmed that Outpatient Transformation Board meetings have continued with representation from both LMCs, PCMs and CCGs and there is a mixed picture but that there is a greater sense of positivity and a shared buy-in to the changes in these pathways.

<u>Follow Ups</u>

The trend analysis shows that the overall volume on the waiting list is reducing, however, this may not be an entirely positive picture. In terms of learning from this, some specialties are looking at virtual solutions with Gastroenterology being the first

to lead in this area. It was noted that we have started to clinically prioritise patients were clinicians assign a priority and it is understood that we are the only Trust who have started an outpatient prioritisation. It was also noted that we have also included clinical validation directly into EPR which will make it easier for clinicians to complete.

In terms of the profile of the priority outpatient status, the 'P' value, this has been broken down with the majority in P3 to P5 but what is not available is how far past that date have patients had to wait, this information will be provided going forward.

The Trust are also piloting 'buddies', staff who will be in regular contact with patients who are waiting. The buddies will work proactively with clinical teams to communicate the outcome of clinical review to patients/GPs so that our patients are kept informed and can highlight any clinical concerns. The EPR Buddy form has now been built and ready to input patient contacts.

Referral To Treatment (RTT)
From an RTT perspective there is a large waiting list with a significant number of >52 weeks. It was noted that work within surgery around consistency of the profiling at P2 has started. It was also noted that we have started to look at the index of multiple deprivation and the priority values. Discussions took place regarding what 'P' value we should look at in more detail and what should be our focus. It was noted that it is important to track those cohorts of patients within the backlog who will have a recurrence of treatment.

Cancer
In terms of Cancer referrals, they are back to pre-COVID levels in most specialties. It is a positive story for the Trust as we have continued to deliver pathways in the same time as pre-COVID and quite a different picture to other organisations.

The Chair thanked the Chief Operating Officer for a very thorough summary of the position. It was noted that it is good to see that we are starting to understand health inequalities, however, it was noted that there is still work to do. From the Committee's point of view, the Chair asked Helen to highlight the 3 areas of major concern to which she called out the following 3 areas of prioritisation:

1. need to clear and retain a good position on the P2s waiting for theatre
2. 6-week element of Endoscopy
3. new patients who have gone through the clinical assessment service but need face to face appointments.

ACTION: To take discussions off-line to identify KPIs and how progress is measured going forward - **RH/HB**

The Committee **NOTED** the content of the detailed presentation and the importance for greater detailed understanding of the Outpatient Backlog for both Executives and Non-Executive Directors.

008/21 MONTH 8 FINANCE REPORT

The Director of Finance highlighted the key points reported at Month 8: -

- The original £1.4m risk within the plan has been covered.
- Forecasting to deliver the Plan of a £1.9m deficit which is a similar position across the ICS.

- Since Month 8, it is assumed that all material costs relating to the vaccination programme which we are hosting at the John Smiths' stadium will be covered and that this will have no financial impact for the Trust.
- Risk relating to the Elective Incentive Scheme has reduced and the impact to Month 8 is £108k which will not impact our overall year-end position.

The Committee were asked to note that the total cost of COVID in the year to date has been £21m which has been reimbursed up to recent times.

The Committee **NOTED** the Month 8 Finance Report with costs still running below plan.

009/21 PLANNING UPDATE

The Deputy Director of Finance provided a paper to the Committee which summarised the latest position. It was noted that National Guidance and timescales have still not been issued, however, correspondence was received prior to Christmas which gave a 'financial steer' not guidance.

It was also noted that a couple of points from that correspondence have been used to inform the assumptions for our early planning which is showing a sizeable financial gap, however, as in past years, there is always the possibility of reducing that pressure through a review period. With the present-day scale of the unknown there is understandably a level of caution built in which could inflate the figure.

The next steps for further refinement will be as follows:

- Review the pressures and developments and facilitate cross-Divisional dialogue.
- Divisional PRMs for January will be used for engagement and review.
- To agree the CIP target – session will be held with Divisional leadership
- To engage with system partners
- Await the publication of the National Guidance and to develop plans on the back of that guidance.

In terms of reporting back to this Committee, it is proposed that a further Update/Draft Plan will be presented at the next meeting with a further update in March and hopefully to progress with a full Plan which can go to Board, acknowledging that there are both internal and external factors which play into this timescale.

The Chief Operating Officer commented that it is important that there is an informed decision-making process of planning and that all potential needs are identified, using risk scoring etc., to get to a final prioritised list. It was noted budget holders are still very much involved in the process.

The Committee **RECEIVED** the Planning Update.

010/21 PHASE 3 ADDITIONAL STAFFING

The Director of Finance introduced the paper which detailed the additional staffing required to cover Phase 3 both on a recurrent and non-recurrent basis. The paper shows that an extra 248 staff were requested which will increase our run rate by an additional £5m of which £3.9m relates to nursing and support to nursing posts**.** The paper goes onto describe that this was the case for Months 7 to 9 but that the impact

was lower than the plan and for qualified nursing the pay bill was fairly consistent which showed that the number of unfilled posts were increasing.

The Deputy Director of Nursing and Infection Prevention and Control went on to give assurance to the Committee of how we are mitigating this risk and providing care for our patients. It was noted that a number of colleagues have been re-deployed, bank and agency staff are also being used and this has slowly increased over the last few months. There are additional controls in place to mitigate the safety aspect which include a daily nursing workstream meeting, a twice daily staffing review, we also have increased our leadership capacity to ensure a Matron is on both sites 7 days a week, in addition, there are different on-call arrangements and therapy staff are deployed who are ward based. Work is on-going with NHSI/E in terms of increasing our Health Care Support (HCS) workers who are also being used to mitigate some of the risk.

The Director of Finance added that the costs included within the Business Case for extra staff which had been approved at Commercial Investment & Strategy Committee had not filtered through due to the challenges with recruitment. Work continues to look at the 'new' normal staffing models which will be looked at within the planning process.

The pressure on staff was also highlighted along with the importance of the Wellbeing Hour, levels of staffing will continue to be monitored closely especially with the possibility of the next surge.

The Committee **NOTED** the strong controls and the various mitigations put in place with regard to the staffing issue which will continue to be monitored by the Committee.

011/21 2021/22 CAPITAL PLAN REVIEW

The Associate Director of Finance highlighted that the Capital Plan had been through the Commercial Investment & Strategy Committee and the Capital Planning Group with a further review at Board. The key points to note are that the Trust has limited capital resource. The Capital Planning Day has prioritised the available resource through presentation of the requirement to the Capital Panel. The Panel propose a capital programme that is within the available resource, has a contingency in place to manage any emerging risks in 2021/22 and proposes utilisation of some of the remaining contingency from 2020/21.

It was noted that the paper going to Board will have an additional paragraph in relation to the nurses' accommodation which was part of the 2020/21 Plan and funded through the critical infrastructure risk, this resource is being managed by bringing forward some schemes from next year into this year as the building is awaiting a bat survey before it can be demolished.

The Committee **APPROVED** the 2021/22 Capital Plan noting the additional paragraph to be included in the paper for Board.

012/21 WEST YORKSHIRE & HARROGATE (WY&H) ICS FINANCIAL RISK

The Director of Finance shared with the Committee the principles which had been agreed by the ICS Directors of Finance should there be a risk to the overall plan.

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

GOVERNANCE

013/21 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Draft Minutes from the Commercial Investment & Strategy Committee held 26 November 2020
- Draft Minutes from the Capital Planning Group held 15 December 2020
- Draft THIS SLA Contract Review held 15 December 2020
- Draft CHFT/SPC Quarterly Meeting held 16 December 2020
- THIS Executive Board held 23 December 2020

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

014/21 WORK PLAN 2020/21

The Work Plan was discussed and the number of items for the February agenda will be reviewed.

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

015/21 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board: -

- UoR position discussed – scoping document to be produced
- BAF Risks reviewed
- IPR - overall monthly performance at 66% with key challenges noted
- Patient Backlog - key priorities identified
- Staffing – challenges of the staffing model discussed; mitigation measures are in place to address risks
- Finance – At Month 8, £1m underspend and planning to achieve the full-year plan
- Planning process outlined
- The Capital Plan for 21/22 was approved by the Committee

016/21 REVIEW OF MEETING

It was noted that the extensive agenda had provided good discussions with a useful deep dive into the outpatient backlog.

017/21 ANY OTHER BUSINESS

There were no further items raised under AOB.

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

NHS
Calderdale and Huddersfield
NHS Foundation Trust

APP A

DRAFT Minutes of the Finance & Performance Committee held on Monday 01 February 2021, 11.00am – 14.00pm Via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Betty Sewell	PA to Director of Finance (Observing)
Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Rhianna Lomas	Finance Secretary (Minutes)
Stephen Baines	Governor representative
Stuart Baron	Associate Director of Finance

ITEM

018/21 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

019/21 APOLOGIES FOR ABSENCE

Apologies were received and noted for Peter Wilkinson.

020/21 DECLARATIONS OF INTEREST

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

021/21 MINUTES OF THE MEETING HELD 11 JANUARY 2021

The Minutes of the Public and Private meetings held 11 January 2021 were APPROVED as an accurate record.

022/21 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed as follows:

125/20 – IPR – July 2020 & Outpatient Improvement Work: It was agreed to defer this action until the 29 March.

149/20 – Stroke Deep-Dive: The stroke indicators review will be seen later in year and the stroke recovery item will be covered in the planning process.

153/20 - NHSI Benchmarking Network: This will be covered in the financial planning process; the Director of Finance and the Chair will discuss this further outside of the meeting. CIP is being discussed outside of the meeting and will continue to be progressed. This will be reported on at a future meeting once a plan has been decided.

005/21 – Matters Arising: The 12-hour trolley waits report went to Quality Committee and the minutes from that meeting will be circulated once available.

The closed items on both the public and private action log were noted by the Committee.

115/20: Business Better Than Usual (BBTU) – The Director of Transformation and Partnerships informed the Committee that the update report included in the papers has previously been submitted to the Transformation Programme Board and the Quality Committee. It was noted that through the involvement of colleagues, partner organisations and members of the public 12 learning themes were identified during June and July 2020 where there was agreement that new ways of working implemented during the pandemic have potential long-term benefit and should be sustained and amplified.

The recommendations within the report were to undertake more work now regarding the initial set up costs to take forward some of the work and to produce more detailed work regarding measurable benefits that CHFT can monitor progress against in the year ahead. This work is now in progress and will come back as a further update in March to the Transformation Programme Board with the aim of taking forward implementation through 2021/22. The enthusiasm of the theme leads was noted, many of whom are clinical colleagues or from partner organisations. They have been keen to take forward the new ways of working despite the pressures they currently face due to Covid.

The Chair spoke on behalf of Peter Wilkinson asking two questions; how are we ensuring no one is left behind on digitalisation due to age or material deprivation? Secondly, how will the health inequalities data affect the prioritisation of patients? Anna Basford assured the Committee that the risk of widening inequalities through digital exclusion has been noted and work is being done with both Kirklees and Calderdale Council to prevent this. CHFT are also reaching out to the local community through listening events so that barriers and solutions can be identified. Regarding patient prioritisation, data is now available on Knowledge Portal Plus that could indicate which groups are being impacted most by waiting times and work is being done to increase awareness from this information. It may be that we undertake action to address the longest waiters in a revised priority order to close gaps. Helen Barker added that focus groups are being conducted with staff to look at the health inequality data as this knowledge will aid recovery however it was noted that recovery will be a long process.

The Chair asked how initial stakeholders will be communicated with going forward? And secondly, will this Committee and others be involved with any of the twelve areas or will it primarily sit with the BBTU group and the Transformation Programme Board? It was noted that updates have been given to the initial stakeholders regarding current progress and an internal newsletter has been circulated. Theme leads are also ensuring they regularly communicate internally with the colleagues in their departments. In March more deliberate communication will be done regarding the benefits. In response to the second question it was noted that each committee should continue to receive updates however the leadership and direction of the project sits with the Transformation Programme Board. The Chair highlighted that this Committee are happy to provide support if necessary.

109/21: Use of Resources (UOR) Scoping Document – The Director of Finance summarised the scoping document. The initial scope would be to look at the key governance forums and describe the decision-making process taken at Incident Management Team (IMT), Capital Management Group (CMG), Commercial Investment & Strategy Group (CI&SG) and our agency discussions. The other area to consider is our staffing resource, a significant amount of CHFT's expenditure relates to staff therefore how much do we want the scope to consider this resource? It was noted that this review could be used to analyse how we have allocated people over the last twelve months and from that, work out what opportunities this gives us for the future. It was noted that the Director of Finance and the Chief Executive had a previous discussion outside of the meeting in which it was decided that it may be useful to gain an external view, therefore Adrian Ennis who has worked with CHFT previously, has been contacted to explore whether he could help.

It was asked if due to a full external review not being undertaken whether we include an independent element. Discussions took place and it was agreed that the Non-Executive Directors will sponsor the work and regularly be involved outside of the meeting. The Chair suggested that the work be linked back to the original assessment and the areas for improvement that were identified. It was also noted that colleagues are working at full capacity due to Covid and work needs to be prioritised. Regarding the scope, the Chief Operating Officer also wanted to ensure that when the expenditure over the last twelve months is assessed, the decisions made at forums other than IMT are reviewed also.

The Director of Finance responded to the various comments by agreeing to summarise early in the report the original position. A governance review combined with the staffing resource considerations will test the latest position against these actions.

The Committee **SUPPORTED** the general scope and the possible external input in relation to staffing reporting back to this Committee in May

ACTION: To report back to this Committee in May – **GB, 5/5/21**

FINANCE & PERFORMANCE

023/21 MONTH 9, FINANCE REPORT INCLUDING HIGH LEVEL RISKS

The Director of Finance highlighted the key points reported at Month 9: -

- The year to date position is favourable by £110k. We are forecasting to deliver the deficit position plan.
- There is a potential risk of being £1m away from the plan therefore conversations have been held with CCG partners and the Mental Health Trust to cover this risk between the organisations. The risk was caused by the decision to increase the annual leave provision at year end due to Covid preventing many colleagues from taking leave. CHFT have in writing from NHSI that increasing our deficit due to this would not affect our overall performance however we are confident that this can be avoided. In summary we are confident of delivering the plan even after covering the additional annual leave provision which would have been an allowable adverse variance.

- Across the Integrated Care System (ICS) at Month 9 we struggled to deliver the target activity however all are forecasting £15m ahead of plan. Discussions are in place regarding what will be done with the surplus. It was noted that it could pose an opportunity to cover a provision related to the Flowers court case and this option is being explored.
- Overall a good position as CHFT and ICS are on target to deliver the plan.

Discussions took place with regard to the cost of agency staff required to cover colleagues taking annual leave. It was suggested that we could buy leave from colleagues at lower cost but this could impact colleagues wellbeing. This requires a full and inclusive debate before a final decision is made.

It was highlighted that Finance have achieved the Better Payment Practice Code due to reaching the 95% target. Finance and Operational colleagues were thanked for their involvement in this.

The Chief Executive suggested that information should be included in the Finance report to better articulate what the CIP information is trying to convey. The Chair also suggested a review of the report as a whole to assess whether it is all still required.

ACTION – To amend the Finance report going forward to either reduce the information being provided or better clarify why it is being provided, even if there is no longer an external reporting requirement. **– KA, 01/03/21**

The Chair queried whether the capital underspending will affect us hitting our revised target of capital spend for the year? It was noted that the Capital plan will be achieved, each scheme is being analysed to ensure orders are in place and on track. It was asked why the aged debt position had increased? The Committee were reminded that the aged debt position had been suppressed by a £1.5m credit to a CCG, this has now been transacted and therefore the position has changed. A second element related to SWYFT, they have moved to processing their invoices through SPS and an error occurred where our invoices were not reaching them. This has now been resolved and will be reflected in the next quarter.

It was noted that a BBTU workstream has been created within Finance and one of these groups will be looking at income and debt. The Director of Finance agreed to share the KPMG benchmarking report as this shows how CHFT compare to other organisations positively regarding aged debt.

ACTION – To circulate the KPMG benchmarking report **– GB, 01/03/21**

Discussions took place regarding the high-level risks, the Committee agreed to reduce the risk relating to this year's Financial Plan from 12 to a 9. The Director of Finance agreed to assess the risk scores of the remaining high-level finance risks noted in the report outside of the meeting and amend them in time for the next finance report.

ACTION: To amend the risk scores of the high-level finance risks in time for the next Committee meeting **– GB, 01/03/21**

The Committee **NOTED** the Month 9 finance report and agreed the change to the risk rating for the 2021 financial plan.

024/21 PLANNING UPDATE

The Deputy Director of Finance briefly explained that clarification has been received regarding the national position for next year and the existing regime will continue in Q1 (potentially into Q2.) Further operational planning guidance will be available from the centre in April. The planning timetable has been revised slightly and the changes can be seen in the papers. Finance continue to plan and the upcoming round of PRMs will be dedicated to planning and will form a key part of the process. Further updates will continue to be received by this Committee. Helen Barker added that the backlog recovery has been separated and this will aid planning and increase focus.

The Committee **RECEIVED** the updated position on the latest national planning guidance and the revised planning time table.

025/21 INTEGRATED PERFORMANCE REVIEW – DECEMBER 2020

The Chief Operating Officer reported that the Trust's performance for December 2020 was 65.7%The following key points were highlighted: -

- The way complaints performance is reported has changed therefore Rachel White will meet with Helen Barker and the DoPs to explain what this means and investigate why performance is low.
- A 10% improvement has been seen regarding stroke admissions.
- Cancer performance is positive, more operating sessions are taking place. However some patients needed subsequent treatment, and this was slightly late. In general CHFT should be proud of how the service has continued. The fast track conversion rate is down, national direction says more patients should be referred however it appears we have a delay regarding routine outpatients therefore this continues to be assessed.
- Long term sick leave is increasing however this is not related to Covid sickness. This will be picked up by the Workforce Committee.
- Regarding the mortality rate, SHMI has increased for 'out of hospital' deaths. There are alerts in place for several specialities therefore this is being discussed with David Birkenhead and Cornelle Parker in order to understand the data further.
- Readmission rates are increasing therefore the work done to reduce this will be relaunched. It was noted that this could be linked to Covid as some pathways like pneumonia and acute bronchitis are more affected by the pandemic. David Birkenhead is reviewing the data.
- Regarding frailty, last December 950 people attended A&E to which 50% were admitted however this December we have seen 900 attend and only 29% be admitted. This shows improvement and has saved the Trust around 1300 bed days. The readmissions for this cohort have also stayed static. This project will be taken to the CI&SC next month to demonstrate the KPIs against the investment.

The Chief Executive questioned whether SHMI needed to be approached with more purpose for example, creating a specific report to be shared with the Quality and Performance WEB in February, which the Chief Operating Officer agreed to create.

ACTION: To develop a SHMI report to go to Quality and Performance WEB in February **– HB, 01/03/21**

The Chair said on behalf of Peter Wilkinson that thanks were to be noted for Peter Keogh for his time spent on the performance management and accountability framework. He also questioned why the complaints performance was particularly low in December, Helen Barker agreed to investigate this and report back next month.

ACTION: To understand why complaints were so low in December and report back the findings at the next Committee meeting **– HB, 01/03/21**

It was queried why head and neck cancer is red when the others are not. It was noted that this is a national pattern as it is a more complex pathway and the bulk of the treatment would go to a tertiary provider of which many are at full capacity.

The Chair asked if the length of the IPR could be reduced. The Chief Operating Officer accepted the challenge; however she is reluctant to take anything out therefore it may be rearranged rather than reduced. Peter Keogh added that we need to bear in mind quality priorities moving forward.

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

GOVERNANCE

026/21 F&P SELF-ASSESSMENT OF THE COMMITTEE'S EFFECTIVENESS – DEADLINE FOR RESPONSES 01/03/21

The deadline of 1 March was noted, and all were encouraged to send their responses to Betty Sewell. The responses will be reviewed at the 29 March meeting.

027/21 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Draft Minutes from the CHFT/CHS Joint Liaison Committee Meeting held 5 January 2021
- Draft Minutes from the Capital Planning Group held 14 January 2021
- Draft Minutes from the CCG A&E Delivery Board held 8 December 2020

The Committee **RECEIVED** and **NOTED** the key points of escalation from the Sub-Committees recognising the achievement of colleagues, both CHS and Trust, to complete Ward 18 in record time to improve patient care.

028/21 WORK PLAN 2020/21

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

A number of items for March have been deferred and the agenda will be reviewed outside of the meeting.

029/21 MATTERS TO CASCADE TO THE BOARD

The following points will be cascaded to Board: -

- An update was given regarding BBTU, further reports will be received in the Spring following discussions at Transformation Board.

- The UOR scoping document was approved. The review will be largely done by the Director of Finance and his team and non-executive input will be given. An external review will potentially be done regarding staffing. Report due early May.
- Month 9 finance report noted. CHFT are on plan despite the annual leave provision. The ICS is also on plan.
- Updated planning guidance has been received however the existing regime will continue in Q1 at least. Further formal guidance will be available from the centre in April. Our plan will be shown at the March 1 Committee meeting.
- IPR showed an overall performance of 65.7%, the following areas for concern were noted regarding complaints performance, increase in long-term sick and increase in SHMI. However, positives were noted regarding, cancer, stroke and frailty performance.
- The impact of our involvement with the vaccine rollout was noted and the John Smith Stadium contract will be reviewed at the March 1 Committee meeting.

030/21 REVIEW OF MEETING

All agreed that the Business Better than Usual and Use of Resources items had been useful.

031/21 ANY OTHER BUSINESS

The vaccine centre contract position in relation to the John Smith Stadium will be shared with the Committee at the next meeting.

ACTION: Review the John Smith Stadium contract at the next Committee meeting **– GB, 01/03/21**

DATE AND TIME OF NEXT MEETING:

Monday 1 March 2021, 11am – 1pm, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 30 December 2020

STANDING ITEMS

194/20 WELCOME AND INTRODUCTIONS

Present

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

In attendance

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

195/20 APOLOGIES

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

196/20 DECLARATIONS OF INTEREST

There were no declarations of interest.

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

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

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

AD HOC REPORTS

198/20 IMPACT ASSESSMENT PROCESS FOR SERVICE CHANGES

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

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

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

OUTCOME: The Committee received and noted the report.

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

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

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

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

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

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

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

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

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

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

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

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

200/20 MAKING COMPLAINTS COUNT

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

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

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

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

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

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

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

CARING

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

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

SAFE

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

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

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

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

In terms of the amber actions:

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

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

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

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

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

203/20 INFECTION PREVENTION AND CONTROL BOARD REPORT

Action: Report to be submitted to the next meeting.

204/20 HIGH LEVEL RISK REGISTER

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

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

The top seven risks scoring 20 and above are:

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

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

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

OUTCOME: The Quality Committee received and noted the report.

WELL LED

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

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

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

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

There has been a recommendation to reword the risk to:

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

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

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

PATIENT SAFETY AND QUALITY BOARD QUARTER 2 REPORTS

206/20 FAMILIES AND SPECIALIST SERVICES DIVISION

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

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

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

OUTCOME: The Quality Committee noted the report.

207/20 MEDICAL DIVISION

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

OUTCOME: The Quality Committee noted the report.

208/20 SURGERY AND ANAESTHETICS DIVISION

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

OUTCOME: The Quality Committee noted the report.

209/20 COMMUNITY DIVISION

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

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

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

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

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

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

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

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

RESPONSIVE

210/20 INTEGRATED PERFORMANCE REPORT

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

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

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

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

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

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

211/20 BI-MONTHLY QUALITY REPORT

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

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

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

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

OUTCOME: The Quality Committee received and noted the report.

POST MEETING REVIEW

212/20 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

The Quality Committee received:

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

213/20 REVIEW OF MEETING

What went well….

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

What could be better……

- If divisions were in attendance

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

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

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

214/20 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

215/20 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix P for information.

NEXT MEETING

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

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

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

QUALITY COMMITTEE

Monday, 25 January 2021

Calderdale and Huddersfield NHS Foundation Trust

STANDING ITEMS

1/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Doriann Bailey **(DBy)**	Assistant Director for Patient Safety
Dr David Birkenhead **(DB)**	Medical Director
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
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Gareth Webb **(GW)**	Interim Senior Risk Manager
Rachel White **(RW)**	Assistant Director for Patient Experience
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Helen Barker **(HB)**	Chief Operating Officer **(item 7/21 only)**
Anna Basford **(AB)**	Director of Transformation and Partnerships **(item 5/21 only)**
Andrea Dauris **(AD)**	Associate Director of Nursing – Corporate **(item 6/21 only)**
Rebecca Sharpe **(RS)**	Project Management Office (PMO) Manager **(item 5/21 only)**
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs

This meeting has adopted the use of a 'reading room' approach for the first time, whereby any reports which are for information, are stored either in the review room on Convene, or in the files section on Microsoft Teams, and not presented during the meeting. It is expected that all meeting attendees read these papers beforehand and any questions or issues relating to the reports can be asked at the meeting.

2/21 APOLOGIES

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

3/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

4/21 MINUTES OF THE LAST MEETING, ACTION LOG AND MATTERS ARISING

The minutes of the last meeting held on Wednesday, 30 December 2020 were approved as a correct record.

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

QUALITY PRIORITY UPDATES

5/21 IMPACT OF BUSINESS BETTER THAN USUAL

Anna Basford (Director of Transformation and Partnerships) and Rebecca Sharpe (Project Management Office (PMO) Manager) were in attendance to provide an update on the focussed quality priority for impact of business better than usual, as detailed at appendix B.

Through the involvement of colleagues, partner organisations and members of the public, 12 learning themes were identified during June and July 2020, where there was agreement by the Trust Board that the new ways of working implemented during the pandemic, have potential long-term benefit and should be sustained and amplified. Each theme has a lead, and a detailed 'blueprint' which sets out the vision and ambition of the theme.

This progress report, which has previously been discussed at the Transformation Programme Board, includes a blueprint for each theme and an aggregated report which shares the key benefits identified. The report was positively received at the Transformation Programme Board and noted that work is yet to be done between now and the end of March 2021 to fully clarify any enabling costs. The aim is that the programme will move forward into 2021-2022 around the delivery programme which will be monitored against those benefits identified in the blueprint.

The frequency of reporting into the Quality committee was discussed, and it was suggested that a quarterly update will be provided, as this is not just about the themes and what they deliver, but also includes the engagement of colleagues, and the way the Trust works with partners and the public, and doing that in a different way. EA stated that one of the reasons why this was included as a focussed quality priority was to ensure that the new ways of working were not having a negative impact on service users, and to ensure that the new ways of working do not have an adverse effect to either colleagues or patients.

The Chair thanked AB and RS for the comprehensive update.

OUTCOME: The Committee noted the report and agreed to the quarterly reporting.

AD HOC REPORTS

6/21 POSITION STATEMENT FROM PERSONAL AND PROTECTIVE EQUIPMENT (PPE) GROUP

Andrea Dauris (Associate Director of Nursing – Corporate) was in attendance to provide an update on appendix C regarding the work undertaken by the PPE Strategic Group, which was established in response to the pandemic. It also forms an element of the focused quality priority on nosocomial infections.

At the start of the pandemic, there was an interrupted PPE supply chain and a rapid piece of work was undertaken to provide assurance and continued supply of PPE to clinical areas. Through the membership of the Group, a daily stock position of PPE was established across the organisation, as well as the development of an escalation plan which described what should be done in the event of a shortage of PPE supplies. It was noted that during the pandemic and continuing, these responses have not been mobilised.

The PPE Group also established a quality assurance process whereby any piece of PPE brought into the organisation, there was a team who would review the equipment to ensure it met with specifications and quality required.

FFP3 was another workstream that the Group had oversight of, which refreshed and approved a new strategy in response to the fluidity of the masks and moved to changing the supply of FFP3 masks in clinical areas. Investment was also made in the supply of positive pressure

hoods. At the beginning of the pandemic, there were approximately 15 hoods in the Trust as part of the response to aerosol generating procedures (AGPs), and this has now been increased to 82 hoods. This put the organisation in a good position regarding the number of hoods, a supply or reusable FFP3 masks and a supply of disposable FFP3 masks. The provision of training in clinical areas for those pieces of equipment was also reviewed.

The PPE Group also responded to rapid changes to national guidance, which led to the development of the 'Trust Greeter' service that was at the main entrances of the hospitals which directly responded to changes in national guidance, but it was also a meet and greet service that reminded people about PPE and responded to any concerns.

The report also describes the health and wellbeing taskforce that was established in response to anxiety in relation to PPE, which consisted of registered nurses who checked with staff regarding PPE supplies, reinforcing good practice, etc. It worked well and dispelled myths in clinical areas and fed back into the PPE Group of actions which were required next.

It was noted that the report links to the nosocomial quality priority, and the key point to make is that an interruption to the supply chain was note experienced and continued to deliver the correct PPE to the right places at the right time, and the work of the Group has now been stood down to a weekly meeting that is building further resilience to clinical areas.

The Chair commented on the excellent report outlining the amazing work done at pace by the Group which had to be extremely responsive as situations changed. The Chair also noted the engagement made with staff to seek their views and feedback and asked if there was a group of staff who struggled with wearing masks and how they were supported. AD stated that the wearing of the FFP3 masks did cause problems for staff particularly in the critical care areas where they wore the masks for a period of time, with noticeable markings across the skin areas of their faces, and part of that feedback from staff led to the development of the rapid pathway from the Tissue Viability team to support the skin damage and to support staff to keep them safe with wearing the devices and looked after their skin. A specific pathway was also developed for the dermatology service.

RW commented on the good report and alerted the Quality Committee to how the role of volunteers will be developed in the future. Following the 'Trust Greeter' service being stood down, and the receipt of concerns into the organisation from the public, this informed the application made to the Winter Volunteering Service for funding, and to look at moving that service forward and supported by volunteers.

EA thanked AD for her stewardship of the PPE Strategic Group.

DBy asked whether there is an improvement with the maintenance of the hoods as there were some previous challenges. AD stated that work is ongoing with the contracting process to ensure there is clear ongoing maintenance of hoods going forward. In addition, the Infection Prevention and Control (IPC) team now have additional resource looking at the FFP3 broad agenda, which includes the hoods and ongoing maintenance.

OUTCOME: The Committee noted the report.

7/21 12-HOUR TROLLEY BREACHES

Helen Barker (Chief Operating Officer) was in attendance to present appendix D, which provides highlights following the review of 12-hour breaches in the Emergency Departments (ED).

The paper describes the situation which arose in quarter 3, during wave 2 of Covid-19, where there was an increase in attendances from positive-Covid and non-Covid admissions, combined with a significant management change in the ED and nurse staffing gaps on the inpatient wards.

Patients were waiting longer for beds and there was discussion regarding the opening up of additional capacity, however, it was felt that this could not be done in relation to safe staffing and it would be safer for patients to be bedded and wait in the ED. There were concerns that this was rapidly becoming normalised, with a high volume of patients waiting longer than 12 hours from a decision to admit, in particular at HRI due to the majority of admissions with a dependency on elderly care facilities being on the HRI site.

A paper was provided for the outer core group that described the decision-making process, and the outcome of the review of those patients. The review has provided assurance in 49 of the 60 cases, that the extended wait in the ED did not appear to have impacted patient outcome. For the remaining 11 cases, a further clinical review was recommended, with three patients needing a more detailed investigation, which is currently ongoing. The actual outcome of those three investigations will need to return to the Quality Committee.

It was noted that the patients in ED were all placed on beds for comfort; where there should have been an intentional rounding and observation on the whole, these were undertaken, however, the Committee cannot be assured that every patient received every bit of intentional rounding and observation, and an action plan has been developed in the ED to ensure that policies are adhered to.

It was also noted that there was one patient who died in the ED who had exceeded the 12 hour wait, and it was suggested that the wait contributed to the patient's demise. EA stated that this case is being taken through as a separate serious incident investigation and is being progressed.

EA stated that the organisation has had a clear position to not move to a 'full capacity protocol' to avoid 12-hour breaches. The protocol would mean moving a patient out of the ED and they would be housed along the corridor in a ward area. It has been made clear that this is not safe or a good experience for the patients.

It was asked that the following elements from the Outer Core Group are incorporated in the paper:

- *an additional recommendation that going forward all patients experiencing a 12-hour delay to their treatment in ED will receive a timely written communication from the Trust apologising for this* - HB noted that the process for apology letters has been restarted via the PALS / Complaints team

- *An explanation / view of why the number of breaches experienced was significantly higher at HRI than CRH* – HB noted that a response to the HRI / CRH split has been provided and allocating timeline and leads for all actions and will be managed through the Performance Review Meeting (PRM) process.

- *For each recommendation a named lead / owner responsible for implementing the recommendation and a target timescale for completion of the action*

- *The report includes that an annual review will be undertaken by the Quality Committee to ensure the actions have been completed and embedded. The use of a 'BRAG' (i.e. blue, red, amber, green) scoring system should be utilised to indicate progress – with blue confirming actions related to each recommendation are fully embedded in practice* – HB suggested that the annual review is done at the end of quarter 4 so it covers the winter period.

Due to the Quality Committee now having responsibility for the overview and monitoring of this, further updates will not be required to be submitted to the Outer Core Group.

The Chair asked how frequently a report or update should be provided to the Quality Committee, and it was suggested that a verbal monthly update on any further 12-hour

breaches could be provided, with a quarterly paper against the KPIs and the annual formal report.

OUTCOME: The Committee noted and agreed the recommendations in the report and the quarterly reporting.

8/21 QUALITY AND SAFETY STRATEGY

Ellen Armistead (Executive Director of Nursing) briefly presented appendix E, which has previously been to the Quality Committee. EA reminded the Committee of the purpose of the Strategy, the links to the visions, values and pledges; the one- and ten-year strategy; the governance framework; the quality account priorities and focused priorities and next steps.

The Committee were asked to acknowledge the amendment of the sub-group reporting structure for the Quality Committee and to agree the next steps going forward.

KH commented on the good document and asked whether this strategy would be communicated to the Council of Governors for information. EA stated that the quality account priorities within the strategy will be discussed with the Governors.

OUTCOME: The Committee noted and approved the Strategy.

CARING

9/21 PATIENT EXPERIENCE REPORT

Rachel White (Assistant Director for Patient Experience) presented appendix F, highlighting ~~work ongoing with complaints service users to gather their feedback in relation to complaints, and work ongoing to recruit for the improvement collaborative~~ ongoing work to develop a survey aimed at gathering service users feedback in relation to the complaints service and to recruit members to an advisory group that will work alongside the improvement collaborative and on co-production projects.

Matters for escalation included:

- The Committee being asked to grant devolved responsibility to the Making Complaints Count Improvement Collaborative in order to sign off on the Service Survey to expedite its use by the Trust.
- The cancellation of the monthly Patient Experience and Caring Group with essential business being carried out via an interim arrangement of revised escalation / modified reporting directly into the Quality Committee.
- The trust being alerted to a risk in relation to commitment to carers. Work is ongoing within the Commitment to Carers workstream to mitigate the risk.

A query was raised on the attached project plan which related to restricted visiting and PPE supply. The key point was that certain groups within the Trust have an agreed approach to support carers being part of the care delivery team for people with particular needs, and there are clear guidelines and support in terms of PPE supply, and how it should be used. However, should the Trust move to a place where wider groups of carers are considered as part of the care delivery team (e.g. carers for people with learning disabilities, autism and dementia), then extra consideration is needed to ensure that PPE match will be available for them.

OUTCOME: The Committee noted the update and were in support of devolving responsibility Making Complaints Count Improvement Collaborative in order to sign off on the Service Survey.

SAFE

10/21 PATIENT SAFETY GROUP REPORT

The Patient Safety Group report was available in the reading room at appendix G.

The Chair raised concerns regarding the lack of future improvement work listed in the report in relation to the Pressure Ulcer Collaborative, and the non-attendance of a representative from the collaborative at the Patient Safety Group. DBy stated that these observations have been noted, and EA noted that following the Board of Directors meeting, Judy Harker (Lead Tissue Viability Nurse) has been asked to undertake a deep dive into pressure ulcers, which will be presented at the next Quality Committee meeting, as there is a definitive link between the operational pressures and pressure ulcer development. Early feedback from the deep dive has shown that there are various pockets of good work being undertaken, however, a focused effort on action planning is now needed. It was also agreed that a dedicated monthly report is required from the Collaborative at the Quality Committee.

The Chair also noted from the report that the last update received from the Resuscitation Group into the Patient Safety Group was in October 2019. DBy stated that an update report was received in December 2020 with queries returned to the leads requesting reassurance on an action plan following an audit, however, representation from the Resuscitation Group has not been present at the Patient Safety Group due to one of the two Resuscitation Officers being off for a period of time. Pressures within the service are recognised, however reassurance is still required from the Resuscitation Group, which will hopefully be provided at the next Patient Safety Group meeting in February 2021.

OUTCOME: The Committee noted the report.

11/21 MEDICATION SAFETY AND COMPLIANCE GROUP REPORT

The Medication Safety and Compliance Group report was available in the reading room at appendix H.

In terms of medical gases, the Chair was pleased to see progress in terms of completing the occupational testing for staff and asked if a company has now been commissioned to carry this out. ES reported that the most cost-effective company was chosen, and checks are being made to ensure they meet the appropriate standards required.

The Chair also showed an interested in the development of the electronic controlled drugs (CD) registers and asked how long the development phase would take. ES stated that meetings are booked over the next three to four weeks with key members of the Trust to review the IT needed, and a product can potentially be ready in the next three months to trial.

ES reported on a noted improvement with the collection of oxygen cylinders, and also noted that following the work carried out with purchasing and installing an active temperature monitoring system in Trust fridges, there is still a concern on what the escalation process will be during out of hours if areas go out of range, and a safe method is still to be decided by the Trust.

DBy also thanked ES for the work done on getting the polymer gel patient safety alert signed off and systems in place to monitor these through pharmacy audits.

OUTCOME: The Committee received and noted the report.

12/21 INFECTION PREVENTION AND CONTROL BOARD REPORT

The Infection Prevention and Control report was available in the reading room at appendix I, highlighting the position of the Healthcare Associated Infections (HCAIs) during quarter 3 in 2020.

David Birkenhead (Medical Director) noted that the report focuses heavily on Covid, however, other infections are still occurring at CHFT. The increase in clostridium difficile cases needs to be monitored and MRSA screening needs to improve. Covid is currently the greatest challenge, particularly in relation to the new variants, the increase in hospital acquired Covid cases and outbreaks over the last few weeks.

There are also a number of challenges regarding the estate - ward designs and ventilation - which are being mitigated.

OUTCOME: The Committee received and noted the report.

WELL LED

13/21 BOARD ASSURANCE FRAMEWORK (BAF) RISK – 4/19: PATIENT AND PUBLIC INVOLVEMENT

Ellen Armistead (Executive Director of Nursing) presented appendix J, providing the outcome of a review of the patient and public involvement BAF risk and a level of assurance in terms of mitigation.

The risk articulation and impact remain the same. The key controls have been reviewed and considered to be relevant and an accurate reflection, however, the BAF has been updated to state that the a Health Inequalities group has been set up to add challenge around the extent to which health inequalities drive service planning. In relation to the gaps in control, and while some activity has been progressed, understandably divisions and teams have had a number of competing priorities to manage against a backdrop of Covid-related staff shortages, and the BAF has been updated to reflect this. Another significant challenge to mitigating the risk is a result of relative visiting restrictions. This has resulted in missed opportunities to gain the views of patients' family and friends in assessing how well the Trust is delivering patient centred care. The BAF has also been amended to reflect this.

The risk rating has been reviewed and given the impact of managing the current phase of the pandemic, the current score has been increased to 16.

The Chair noted that this has been a comprehensive review and noted that the risk score has increased to 16, as well as the list of ongoing positive assurances, in spite of all the challenges.

OUTCOME: The Committee noted and approved the recommendations and updated BAF.

14/21 BOARD ASSURANCE FRAMEWORK (BAF) RISK – 6/19: COMPLIANCE WITH QUALITY AND SAFETY STANDARDS

Ellen Armistead (Executive Director of Nursing) presented appendix K, providing the outcome of a review of the compliance with quality and safety standards risk.

There has been very little in the way of external reviews during the pandemic, which was a deliberate strategy of the arms-length bodies to reduce the burden on organisations, however, making a judgment on the overall effectiveness of mitigating actions becomes more challenging to assess. The CQC and Compliance Group has continued to meet and the should and must do's following the last CQC visit have been resolved and are due to be closed.

Internal monitoring has continued throughout the pandemic and ward / service level assessments have been further developed.

The risk articulation and impact remain the same. Key controls have been updated to reflect a refresh of the risk management strategy, a review of the Quality Governance structure and the agreement of the Learning and Improving: Quality and Safety Strategy. The positive assurances remain relevant, however, with no new external reports, the external validation becomes difficult. The gaps in controls remain a risk, in relation to the capacity of serious incident investigators to undertake a review in a timely manner. Work to develop a strategy to resolve this is underway. The risk rating has been reviewed and remains the same, and the gaps in assurance reflects the move away from non-essential activity by regulators.

The Chair asked how the further work which needs to be developed to understand the impact on care standards as a result of the pandemic response, clinical prioritisation and staff shortages will be done and taken forward. EA reported that clinical prioritisation is now a focused quality priority and a key issue in assessing whether there have been any deficits in care as a result of how the Trust has had to operate throughout the pandemic, so this is ongoing. In relation to the staff shortages, there are several good systems and processes in place which have been better utilised to respond to staff shortages as a result of the pandemic, however, nationally, it is not known how long it will be before this is resolved.

OUTCOME: The Committee noted and approved the recommendations and updated BAF.

15/21 QUALITY COMMITTEE TERMS OF REFERENCE

The Committee's terms of reference have now been updated to includes the Assistant Director of Patient Experience to the membership, and were available in the reading room at appendix L.

OUTCOME: The Committee noted and approved the change to the terms of reference.

RESPONSIVE

16/21 ANNUAL LEGAL SERVICES REPORT

The annual legal services report was available in the reading room at appendix M, highlighting the claims and inquests during 2020.

OUTCOME: The Committee noted the report.

POST MEETING REVIEW

17/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

The Quality Committee received:

- The final quality and safety strategy
- The 12-hour trolley breaches report and noted that the Committee is taking over the responsibility for the monitoring of progress in regard to the recommendations
- The deep dive into the Board Assurance Framework risk for Patient & Public Involvement (4/19), which has been increased to a score of 16
- The deep dive into the Board Assurance Framework risk for Compliance with quality and safety standards (6/19)

18/21 REVIEW OF MEETING

What went well….

- The revised way of separating the reports for background reading, which allows members to have pre-formed questions and contributions ready for those reading materials and not spending unnecessary attention where not needed.

19/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

20/21 CQC AND COMPLIANCE GROUP TERMS OF REFERENCE

The CQC and Compliance Group terms of reference were available in the reading room at appendix N.

OUTCOME: The Committee noted and ratified the terms of reference.

21/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix O for information, and the Chair noted that the workplan is due to change once the revised sub-committee reporting as noted at item 8/21 is in place.

NEXT MEETING

Monday, 22 February 2021 at 3:00 – 4:30 pm on Microsoft Teams

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS				
30.12.20 (205/20)	**BAF Risk 3/19: seven-day services**	David Birkenhead / Cornelle Parker	DB stated that every effort will be made to complete the audit to provide the Quality Committee with a level of assurance in relation to compliance. **Action 30.12.20**: DB to follow this up with CP, DBy and RW regarding resources needed to complete the audit **Update: Completion of audit to be confirmed**	
26.10.20 (184/20)	**Bi-monthly report**	Gill Harries, Louise Croxall, Julie Mellor	**Action 26.10.20:** Gill Harries and Louise Croxall to be invited to a future Quality Committee to discuss their plans to manage the risk of a split-site paediatric service. **Update: see agenda item 26/21**	**See agenda item 26/21**
FORTHCOMING ACTIONS				
5.2.20 (21/20) 28.9.20 (154/20) 30.12.20 (matters arising)	**Outpatients improvement plan**	Helen Barker	**Update 30.12.20:** In relation to the update received from the outpatients' action plan, EA noted that reference to the risk register is made in relation to a closed risk on outpatient delays, however, the risk relates to a new risk on COVID-related delays. Due to the change in circumstances due to the delays as a result of COVID, could HB attend QC to provide updates on all outpatient risks that have been included in the COVID-related risks, as there have now been changes. **Action 30.12.20:** That Helen Barker attends to provide update on outpatient COVID-related risks	**DUE Monday, 22 March 2021**
26.10.20 (181/20)	**Medical examiner update**	Dr Tim Jackson	Following a verbal update from CP, it was agreed that Dr Tim Jackson is invited to the next Medical Examiner's update in April 2021 **Action 26.10.20**: Dr Tim Jackson (Lead Medical Examiner) to be invited to the Quality Committee meeting to provide the next update in six months' time.	**DUE Monday, 19 April 2021**
CLOSED ACTIONS				
30.12.20 (199/20)	**Superabsorbent polymer gels**	Doriann Bailey	In relation to areas that use Vernagel super absorbent sachets, but do not stock controlled drugs therefore, will not be audited by pharmacy as part of their safe storage of controlled drugs audit, DBy asked how it will be assured that there are no missed opportunities in the monitoring and auditing of those areas. EA stated that this should form part of the matron's audit, and that a spot-check audit takes place in six months' time to ensure compliance in dermatology CRH, angiography CRH and radiography HRI, as outlined in the appendix of the report. **Action 30.12.20**: DBy to contact Jean Robinson (Senior Infection Control nurse) to add the superabsorbent polymer gel check to the frontline ownership (FLO) audit. **Update: JR agreed to add compliance checks to the FLO audit.** **DBy also reported that she had met with Richard Hill (Head of Health and Safety), who will be adding the three areas above to the Health and Safety monthly checks going forward.**	**CLOSED 25 January 2021**
30.12.20 (201/20)	**Quality Account priority – learning lessons to improve patient experience**	Rachel White	Rachel White (Assistant Director for Patient Experience) presented appendix E, which was detailed in the report provided at item 200/20. RW summarised that previous work has taken place in relation to the learning portal, and further discussions are needed on what this work entailed. **Action 30.12.20**: Further update to be provided once this is known. **Update: See matters arising – Work on this priority had paused this month in light of a focus on the Making Complaints Count Collaborative & associated activities. This priority now sits within the Making Complaints Count Improvement Collaborative workplan.**	**CLOSED 25 January 2021**
30.12.20 (206/20)	**FSS Terms of Reference**	FSS Division	The terms of reference of the division's Patient Safety and Quality Board meetings were also circulated for ratification from the Quality Committee, and it was noted that the administrative support on the terms of reference would need to be revised, as well as the addition of divisional patient experience and quality support leads on the membership of the PSQBs. **Action 30.12.20**: The terms of reference to be returned to the division for the relevant amendments to be made and returned to the Quality Committee for ratification. **Update: Action forwarded to division**	**CLOSED 25 January 2021**
2.9.20 (133/20)	**Quality priority – falls resulting in harm**	Denise Sterling	**Action 2.9.20**: HH to take comments back to the Falls Collaborative to reconsider the 10% reduction target and to provide further assurance to the Quality Committee **Action 2.9.20**: The equality impact assessment to be completed. **Action 2.9.20**: Benchmarking data from other Trusts to be added to the monthly falls dashboard. **Update 26.10.20:** Reminders sent on 1 October and 20 October – no response received as yet. Further update to be requested from the Falls Collaborative. **Update November:** Deadline date provided for update **Update 30.12.20:** Update received from Falls Collaborative as attached. Discussion ensued on the response received and it was agreed that it should be referred to the Clinical Director for the medical division. The Chair noted that the response did not provide assurance on the safety of patients in terms of falls. It was also noted that complex complaints of repeated falls are currently taking place and could be avoided if a robust falls programme is in place. In relation to IT support and provision of fall sensors, it was agreed that these risks are highlighted in a paper for from the Falls Collaborative and escalated to the Quality Committee. **Action 30.12.20**: DS to follow this up with the Clinical Director for the medical division. **Update: Chair actioned with Clinical Director, who will address the concerns raised**	**CLOSED 25 January 2021**
1.7.19 (120/19) 2.3.20 (41/20)	**Serious incidents deep dive**	Senior Risk Manager	**Action 1.7.19**: OW to be invited to a future meeting to present next steps. **Update 29.7.19:** Work is ongoing to review systems and processes, with an action plan being pulled together. **Update 30.9.19:** A three-month update was provided – see item 176/19 **Action 30.9.19**: Further update to be provided in six months' time, and maybe earlier if improvement and sustained change is not noted. **Update 2.3.20:** Following discussion on target timescales of between 25 to 40 working days for responding to complaints, it was queried why the same timescale cannot be delivered for serious incidents. **Action 2.3.20: Deep dive into serious incidents to take place.** **Update September: MT reported that a conversation with the new Assistant Director for Patient Safety will need to take place regarding plans going forward with serious incident investigation capacity. This item to be deferred.** **Update: Audit Yorkshire is in the process of commencing a deep dive of the incident management process.**	**CLOSED 25 January 2021**
30.12.20 (203/20)	**Infection prevention and control board report**	David Birkenhead	**Action 30.12.20**: Report to be submitted to the next meeting. **Update: See agenda item 12/21**	**CLOSED 25 January 2021**

Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE – DEEP DIVE

Held on Monday 8 February 2021, 3pm – 5pm
VIA TEAMS

PRESENT:

David Birkenhead	(DB)	Medical Director
Gary Boothby	(GB)	Director of Finance
Mark Bushby	(MB)	Workforce Business Intelligence Manager
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Jude Goddard	(JG)	Governor
Karen Heaton	(JH)	Non-Executive Director (Chair)
Andrea McCourt	(AMc)	Company Secretary

IN ATTENDANCE:

Leigh-Anne Hardwick	(LAH)	HR Business Partner (for item 08/21)
Nikki Hosty	(NH)	FTSU/ED&I Manager (for item 11/21)

01/21 **WELCOME AND INTRODUCTIONS:**

The Chair welcomed members to the meeting.

02/21 **APOLOGIES FOR ABSENCE:**

Ellen Armistead, Deputy Chief Executive/Director of Nursing
Helen Barker, Chief Operating Officer
Denise Sterling, Non-Executive Director

03/21 **DECLARATION OF INTERESTS:**

There were no declarations of interest.

04/21 **MINUTES OF MEETING HELD ON 9 DECEMBER 2020:**

The minutes of the Workforce Committee meeting held on 9 December 2020 were approved as a correct record.

05/21 **ACTION LOG – FEBRUARY 2021**

The action log was reviewed and updated accordingly.

06/21 **MATTERS ARISING**

Hot House Topics
Committee members had been given opportunity to express their preference of topic choices, in preference order these are:-

1. Management skills required in a post COVID world
2. Inclusion and Health Inequalities
3. Review of The Cupboard, including how our workforce strategy is aligned with the NHS People Plan
4. One Culture of Care meets Time to Care – how the two strategies work together

Four 2021 Hot House dates are scheduled. The first Hot House date (8 March) is dedicated to NHS Staff Survey – Divisional Trust plans and Trust wide plans, therefore number 4 above will be the subject of a Workforce Committee Deep Dive meeting.

Hot Houses will continue via Teams for the present time and when safe to do so will take place face to face along with Teams option to support attendance.

JG noted an experience where she had felt her attendance at an event not appropriate and asked how Hot House events were managed to ensure all participants feel included. SD recognised that pre-briefings for facilitators and appropriate introductions, along with careful planning of break-out groups/networking opportunities is critical to empowering colleague participation and contribution.

OUTCOME: The Committee **RECEIVED** and **AGREED** the approach to Hot House events.

At this point KH asked if an overview of the NHS People Plan would be provided to the Committee. SD reported that a gap analysis had been carried out to identify how CHFT matched against the national priorities and agreed to circulate the report to the Committee and this item will be added to the March Committee agenda for discussion.

Action: Circulate CHFT actions against NHS People Plan (SD).

Workforce Committee Self-Assessment Action Plan 2019/2020
JE presented the action plan developed to improve consensus and address comments made by Committee members in the self-assessment. The Committee noted four key areas of focus:

- Have in our minds the Committee workplan
- Core member attendance
- Core member participation across agenda items during meetings
- Divisional input to agenda items.

Progress on actions will be reviewed alongside the commencement of the next self-assessment exercise which is due to commence in April in order for the 2020/2021 Workforce Committee Annual Report to be submitted to the July Audit and Risk Committee.

OUTCOME: The Committee **RECEIVED** and **SUPPORTED** the actions to improve Committee feedback and respond to comments.

07/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – JANUARY 2021**

MB presented the report.

Summary
Performance on workforce metrics continues to be high and the Workforce domain increased to 71.2% in December 2020. This is the second month in 19 where the domain score is 'Amber'. 5 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', 'Sickness Absence Rate (rolling 12 month)' 'Long term sickness absence rate (rolling 12 month)' 'Short term sickness absence rate (rolling 12 month), and Data Security Awareness EST compliance. Medical appraisals are on hold due to the current Covid-19 pandemic.

Workforce – December 2020
The Staff in Post increased by 70.46 FTE, which, is also due, in part, to 8.33 FTE leavers in December 2020. There has also been a decrease of 2.42 FTE in the Establishment figure, along with student nurses leaving.

Turnover increased to 7.47% for the rolling 12 month period January 2020 to December 2020. This is a slight increase on the figure of 7.24% for November 2020.

Sickness absence – December 2020
Sickness absence reporting has been revised and now reports on the previous month compared to 2 months behind as previously.

The in-month sickness absence decreased to 5.04% in December 2020. The rolling 12 month rate increased marginally for the fifteenth consecutive time in 25 months, to 4.46%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 32.02% of sickness absence in December 2020, increasing from 29.81% in November 2020.

The RTW completion rate decreased to 51.61% in November 2020.

Essential Safety Training – December 2020
Performance has improved in 5 of the core suite of essential safety training. With all 9 above the 90% target with 4 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance decreased to 95.16% and is above the stretch target again following last month's increase and is above the stretch target for the fifth time since July.

Workforce Spend – December 2020
Agency spend increased by £0.17M, whilst bank spend also decreased by £1.32M.

Recruitment – December 2020
4 of the 5 recruitment metrics reported (Vacancy approval to advert, Shortlisting to interview, Interview to conditional offer, Pre employment to unconditional offer) deteriorated in November 2020. The time for Unconditional offer to Acceptance in December 2020 increased and was just under 2 days.

KH noted the low compliance in RTW interviews acknowledging this item is for further discussion in a separate agenda item.

Covid vaccinations were noted at approximately 75% with a further 5% to be validated. JG asked what the position is regarding colleagues not wishing to have the vaccine. DB confirmed that whilst the vaccine is not mandatory, infection control measures must be adhered to. Some colleagues choose not to have the vaccine believing they are already protected having had Covid. Midwifery colleagues are working to address fertility concerns. A campaign is underway to reassure BAME colleagues. Some colleagues have been unable to receive the vaccine due to having Covid infection in last 4 weeks.

KH raised the matter of the Trust's workforce age profile noting in particular the over 55s position.

Action: Provide analysys of CHFT age profile at next meeting (MB).

The Committee noted an inconsistency in agency/bank spend. Figures would be reviewed and confirmed.

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

08/21 **RETURN TO WORK INTERVIEWS**

LAH provided an updated on the compliance position for return to work interviews and described the steps being taken to improve compliance.

The compliance rate for return to work interviews has seen an ongoing decline since the end of 2019. Seeing its lowest compliance figures in 2020. The metric has not achieved its 95% target in the last 24 months. There had been confusion about which system to record the date for areas that have transferred to the Healthroster system. Managers outline a good understanding of the process, purpose and benefits of completing the interviews, this is not reflected in the compliance data. The HR team has implemented a series of focussed actions to support improvements. Internal compliance will ensure the target of 95% is achieved by 1 April 2021. NH added that the role profile of the two new Wellbeing Advisors includes support to the HR BPs.

Action: RTW compliance position to be reported at May Committee meeting (LAH).

OUTCOME: The Committee **NOTED** the actions to support improvements.

09/21 **PAY ANOMALIES**

JE presented a report which provides information about an exercise to examine payments made to employees in the Trust that fall outside nationally agreed and locally implemented terms and conditions of employment. The report explained pay, terms and conditions arrangements in the Trust are governed by nationally determined agreements for all staff groups. National agreements are largely prescriptive in terms of the what and why though there are some areas where principles have been agreed for local negotiation to determine the appropriate response and limited flexibilities for employers in respect of local pay schemes. Whilst giving consideration to pay arrangements in the context of the Covid pandemic a number of historical pay arrangements operating outside of national terms and conditions were identified

It has been agreed that these arrangements should be reviewed to determine their appropriateness. A review of the payments will be led by the operational HR team in conjunction with service leads. The timeframe for completing the review is 30 April 2021. GB commented on the degree of input to progress the work required once the review is complete. On completion of the review the recommendations will be presented to Executive Board. An updated will be provided to the May Committee meeting.

Action: Review outcome to be presented to May Committee meeting (JE)

OUTCOME: The Committee **NOTED** and **SUPPORTED** the review exercise on pay arrangements.

10/21 **2020 NHS STAFF SURVEY**

NH informed the Committee the indicative results had been received, embargoed until 11 March 2021. The Committee noted CHFT response rate increased from 45.7% in 2019 to 50.1% in 2020. NH provided an overview of the results. Initial indications show an overall improved engagement score. NH outlined the Trust's strategy response which comprises:-

- Development of a Trust wide action plan focusing on key priorities with progress against actions monitored at Workforce Committee
- Development of Division action plans with progress reported at Performance Review Meetings
- Focus on key teams, areas, staffing groups and themes

Aligning to the NHS People Plan, trust-wide key priorities have been identified as follows:-

- Health and Wellbeing
- Leadership Development
- Development opportunities for all

- Inclusion
- I am a member of Team CHFT

GB queried if all areas are developing action plans and NH confirmed that HR BPs are working closely with all divisions and directorates to support production of detailed action plans.

DB asked if more detail was available in terms of respondents' age groups. JE advised that whilst we are able to do some analysis on the indicative results, more detail will be available once the embargo is lifted on 11 March.

KH was pleased to see so many positive results particularly during the pandemic period. KH commented that annual surveys don't always allow the time to respond and measure differences. JE advised NHSE/I is giving consideration to the use of quarterly pulse surveys in addition to the annual survey.

OUTCOME: The Committee **NOTED** the initial results and the positive news.

11/21 **BOARD ASSURANCE FRAMEWORK (BAF)**

AMc presented the BAF. The BAF risks were reviewed at the Audit and Risk Committee on 26 January 2021 and will be presented to the Trust Board on 4 March 2021.

AMc confirmed three of the risks have been updated with the fourth (medical staffing) in progress. Updates will be provided to the Board. The Committee noted that colleague engagement risk (risk 12/19) is one of three risks being reviewed by Internal Audit as part of its end of year Head of Internal Audit Opinion on internal controls which informs the 2020/21 annual report.

On review at the Audit and Risk Committee, it was proposed the Workforce Committee should be asked to consider the change of risk appetite category for risk 10a, 10b and 11/19 to the workforce category. Following discussion members agreed to retain the existing categories.

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

12/21 **ANY OTHER BUSINESS**

No other business was discussed.

13/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Hot House topics
NHS People Plan
Analysis of workforce age profile
Staff Survey
Return to Work Interviews
BAF

14/21 **EVALUATION OF MEETING**

SD supports HS attendance as maps across staff side issues. GB and DB participation in terms of cross over. JG contributes to patient insight. JG pleased to see good introductions and welcomes seeing people on camera during the meeting.

15/21 **DATE AND TIME OF NEXT MEETING:**

8 March 2021:

9.30am-11.30am: Workforce Committee Hot House – Divisional Presentations of Staff Survey Action Plans

11.45am-12.45pm: Review of Quality & Performance Report (Workforce)

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Covid-19 Oversight Committee
Tuesday 26 January 2021 - 11.00 am – 12.00 pm
Microsoft Teams

PRESENT

Denise Sterling – Chair (DS)	Non-Executive Director
Karen Heaton (KH)	Non-Executive Director
Andy Nelson (AN)	Non-Executive Director

IN ATTENDANCE

Anna Basford (AB)	Director of Transformation and Partnerships
Andrea McCourt (AM)	Company Secretary
Linda Cordingley (LC)	Minutes
Peter Keogh (PK)	Assistant Director of Performance
Calum McIver (CM)	Head of Corporate and Primary Care Information

01/21 APOLOGIES FOR ABSENCE

There were no apologies for absence.

02/21 KNOWLEDGE PORTAL

DS welcomed Peter Keogh and Calum McIver to the meeting to demonstrate information available on Knowledge Portal to support the management of the hospital and community services through a suite of models. Members welcomed the level of detail available.

It was noted that there appeared to be differences in the data in Wave 1 and Wave 2, noting the increased Length of Stay (LoS) and less patients in ICU, which may translate to lower mortality rates. CM said there was a number of different factors which would require clinical input to confirm this supposition. In terms of benchmarking against other organisations CM advised that we were looking at national data, which would help us to determine the best treatment and best outcomes. DS asked if we were capturing those patients who were discharged which may be referred to other services in the community due to long Covid. CM advised that readmissions were tracked but the Knowledge Portal does not currently capture on-going support and care provided in the Community for Covid patients following hospital discharge. It was noted that there was work around population health management across the system to support partnership working and collaboration. It was recognised that CHFT was in a good position with data analysis relative to IMD and other characteristics, which was underpinned by our EPR system. This had enabled the Trust to develop a wider set of skills amongst colleagues to access and use the live data.

03/21 NOTES OF THE LAST MEETING

The notes of the meeting on 22 December 2020 were approved.

04/21 12-HOUR BREACH INVESTIGATIONS UPDATE

AB advised that the Outer Core Group had sought assurances around the processes of investigation, awareness of the timescale for completion of the investigations and that learning was embedded. The Outer Core Group had received an update on 15 January 2021, which was a draft of the paper to be submitted to the Quality Committee. The Outer Core Group asked for some additions to the paper and for assurance to be monitored by the Quality Committee.

DS advised that the final paper had been discussed at the Quality Committee on 25 January 2021 and it had been agreed to assume responsibility for the overview and monitoring of the recommendations. The frequency of updates to the Quality Committee, commencing February 2021, had been agreed which would provide the appropriate governance and assurance. DS said that further escalation to the Board of Directors would be made if required.

AB advised that there had been no further surge in 12-hour breaches.

The Committee **NOTED** the update.

05/21 TESTING CAPACITY UPDATE

AB advised that our testing capacity had recently been reduced due to one of our machines not being sensitive to the new Covid variant. There was a short period when there was reliance on Mid Yorkshire for testing, with some point of care testing as a standby. This decision had been made in the interests of colleague and patient safety. The Trust was alert to the fact that limited inhouse testing capacity could result in slowing down decisions for admission, which could impact on flow. A further update to the Outer Core Group had confirmed that both testing machines were now operational and inhouse capacity had been restored.

It was noted, however, that reagents for one of the testing machines had already been purchased at a cost of £500k. These abortive costs were being pursued with NHSE as Covid-related costs.

The Committee **NOTED** the update.

06/21 OUTER CORE REGISTER OF DECISIONS

The Register of Decisions from the Outer Core Group was received. Actions due at the end of the month would be considered by the Outer Core Group and an update provided to the next meeting.

Wave 2 planning – update on 12-hour breaches – this item was closed.

07/21 FUTURE TOPICS/ISSUES FOR CONSIDERATION

AB advised that the Outer Core Group had requested views from the Oversight Committee on a proactive focus on broader challenges for the future. The following items had been identified for consideration:

1. Vaccination uptake and health inequalities
2. Review of Covid-19 deaths at CHFT and benchmarking – outcomes between 1st and 2nd waves
3. Review of hospital acquired infections (HAIs) at CHFT and benchmarking – it was noted that this was a growing issue across all Trusts. The Outer Core Group would define the scope of this work and provide assurance to the Oversight Committee.
4. Medium to Longer Term mental health impacts on colleagues of Covid-19 and actions to address – an indication would be available from the staff survey results published in March.

The above prioritisation was agreed.

AN said that prioritisation and the backlog challenge was another important item which would receive focus at the next meeting of the Board of Directors.

08/21 DATE AND TIME OF NEXT MEETING

The next meeting was scheduled for Monday 22 February 2021 – 9.00 am – MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 26 January 2021 commencing at 10.00am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Gary Boothby	Director of Finance
Kirsty Archer	Deputy Director of Finance
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Kim Betts	Interim Internal Audit Manager, Audit Yorkshire
Steve Moss	Anti-Crime Lead, Audit Yorkshire
Mandy Griffin	Managing Director, Digital Health
Clare Partridge	Partner, KPMG
Amber Fox	Corporate Governance Manager (minutes)
Doriann Bailey	Assistant Director of Patient Safety **(for items 5/21, 6/21, 7/21, 8/21)**
Gareth Webb	Senior Manager, Quality and Safety **(for items 5/21, 6/21, 7/21, 8/21)**
Richard Hill	Head of Health and Safety **(for items 16/21 and 17/21)**
Leanne Sobatree	Internal Audit Manager, Audit Yorkshire

01/21 APOLOGIES FOR ABSENCE

Apologies were received from Salma Younis, Senior Manager, KPMG. Clare Partridge joined the meeting from item 07/21 onwards.

The Chair welcomed everyone to the Audit and Risk Committee meeting and introductions were made.

02/21 DECLARATIONS OF INTEREST

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

03/21 MINUTES OF THE MEETING HELD ON 21 OCTOBER 2020

The minutes of the meeting held on 21 October 2020 were approved as a correct record subject to the following amendments.

Information Governance Deep Dive - page 2

Three ICO reportable incidents occurred between April 2019 to September 2020, with no further action to be taken, by the ICO.

Local Counter Fraud Progress Report - page 7

RH asked for clarity on the wording 'the timetable of work for compliance was making staff aware their data is used as part of the exercise.' Steve Moss confirmed there is a timetable of work to make staff aware their data was being used in the compliance exercise. The minutes will be re-worded.

AN asked for an update on the timing of the re-tender exercise with external audit. The Deputy Director of Finance confirmed the Trust is planning for this with the procurement team for completion by September/October 2021. The selection of the auditors requires approval by the Council of Governors meeting in October and Zoe Quarmby is working on the timeline. The Director of Finance raised a concern about the ability to appoint an

external auditor following challenges other Trusts have had generating interest from external audit firms. The Committee will be kept informed of progress.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 21 October 2020 subject to the amendments above.

04/21 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updated accordingly.

Review of Losses and Special Payments – RH noted the CHFT Assistant Director Patient Experience is the budget holder who reviews and signs off the payments and asked if there is a limit on the amount that can be approved. The Deputy Director of Finance re-assured the Committee that this is in line with authorisation limits of the individual and follows the delegated authority for approval. Action closed.

The duplicated action for Consultant job plans will be combined into one action.

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

05/21 RISK MANAGEMENT REVIEW DEEP DIVE

Gareth Webb, Senior Manager for Quality and Safety presented a deep dive on risk management services which focused on the Risk Management Strategy and Policy which included risk governance, risk registers and processes.

The Risk Management Strategy has undergone a review and rationalisation and the strategy and policy have been combined into a single document. The Risk Management Strategy is currently going through consultation prior to March 2021 Board approval.

The risk register and processes are undergoing improvements which is supported by the updated Risk Management Strategy.

Gareth provided an update on Covid-19 risk management and explained a daily incident management team meeting takes place which is very well attended. There is a designated Covid-19 Workstream risk register report which is linked to the high-level risk register.

Doriann explained as part of the changes to the Risk Group there has been an increase in time to allow for more robust discussion on risks mitigation and scores at the meetings. The presence of the Director of Operations from each Division ensures engagement with the Divisions. The Assistant Directors of Nursing are also being invited to the meeting to review clinical risks which adds value. The consistency in the divisional risk reports is being reviewed to ensure the presented information provides assurance that the risks have been robustly reviewed. AN said it is very positive the Divisions are now more engaged.

AN asked if there is a focused review of the red Covid risks. Gareth confirmed new and updated Covid risks are escalated, reported, and reviewed at each meeting. The key Covid risks relate to staff and work pressures and support that they can be given during this pandemic.

DS thanked the team for their work on the risk register to make it clearer and more consistent and highlighted the importance of maintaining this. The Company Secretary attends the Risk Group and explained the Strategy will help clarify the process of agreeing which risks with a score of 15 or more are escalated onto the high-level risk

register. Divisions often have risks at 15 or above which should not automatically go onto the high-level risk register without a discussion and understanding of the risk.

OUTCOME: The Committee **NOTED** the details provided in the Risk Management Deep Dive presentation.

06/21 RISK MANAGEMENT STRATEGY

Doriann Bailey, Assistant Director of Patient Safety presented the updated Risk Management Strategy. She highlighted there has been a subsequent update to page 21 - risks scored higher than 15 will be brought to the Senior Risk Manager, rather than the Company Secretary.

The Company Secretary explained on page 9 there has been a recent agreement that the compliance aspects of the CQC and Compliance Group will be reported into the Audit and Risk Committee and asked if this can be updated in the Strategy. **Action**

RH stated it is a much more improved and concise document. He highlighted page 16 which states 'the assessment of risk within the BAF is reviewed by the relevant Board Committee' and explained specific risks have been allocated to Committees to ensure they focus on these and report back and asked if this can be further described in the Strategy. **Action**

RH highlighted page 21-22 of the report which explains that high-level clinical risks are reviewed by the Quality Committee and asked if other Committees also review the high-level risk register, stating this takes place at the Finance and Performance Committee. The Committee were not confident that this happens at each Committee. This will be discussed by the Non-Executive Directors at one of their regular meetings.

RH pointed out the role 'Health and Safety Advisor' in appendix 4 should be corrected to 'Head of Health and Safety'. **Action**

AN asked if the Transformation Programme Board can be added in Section 8 to describe their role in risk management. **Action**

AN asked for clarity on the terms 'significant risk' and 'corporate risk register'. Gareth will review these terms and clarify the definitions in the Strategy. **Action**

AN stated he had several other more minor points to make and will pass these on to Gareth and Doriann. **Action**

The Company Secretary highlighted the most up to date Trust Committee structure is presented on page 30, which includes the revised Quality Committee governance reporting arrangements that are being embedded.

OUTCOME: The Committee **APPROVED** the updated Risk Management Strategy subject to the changes above and **NOTED** the Strategy will be revised and updated prior to presentation to the Board for approval on 4 March 2021.

07/21 RISK GROUP TERMS OF REFERENCE

The Risk Group terms of reference were presented for approval, following a refocussing of the group on risk, with the compliance aspects previously considered by the group now being reviewed in the CQC Compliance Group. Doriann highlighted a subsequent small change to the membership in the terms of reference which was circulated this morning.

Clare Partridge, Senior Manager from KPMG joined the meeting.

The Company Secretary suggested the review of the Divisional risk registers should be added under duties of the Risk Group in section 4 as this is a significant part of this Group's role.

AN stated the membership in section 5 describes 20 members and asked if the Directors of Operations and Associate Directors of Nursing are required as members or only invited as necessary. Doriann clarified the Directors of Operations and Associate Directors of Nursing are not core members and are invited as needed. **Action: Doriann to articulate this in section 5**

AN felt that seven attendees was a low number for quorum to effectively achieve the business of the group, as detailed in section 10. Doriann confirmed the Directors of Operations are now invited and an increase in quorum of this Group will be reviewed. The Director of Finance pointed out this may relate to historical poor attendance. He suggested a mix of representatives is specified for quorum of the group, e.g. a specific number of clinical staff and representatives from all Divisions. Doriann stated there was valuable contribution from the Directors of Operations and the aim is for this to continue, or for the Assistant Directors of Nursing to attend in their place. **Action: Doriann to review the quorum number**

OUTCOME: The Committee **APPROVED** the updated Risk Group Terms of Reference subject to the changes described above.

08/21 CQC AND COMPLIANCE GROUP TERMS OF REFERENCE

Doriann explained compliance was previously part of the Risk Group (formally Risk and Compliance Group) and there was a decision made last October to add the compliance element to the CQC Group as this was more fitting. The revised terms of reference reflect this change and work is ongoing to reflect this in the agenda. The compliance element of this Group will report into the Audit and Risk Committee agenda on a quarterly basis.

AN asked if clearer reference can be made to the scope of compliance in section 2.1, for example, a list of all the compliance registers mentioned in the Risk Management Strategy or attach a similar register to the terms of reference. Doriann will make the scope of compliance more explicit or include an appendix. **Action**

AN asked if section 4.2.3 referring to audit is referencing the internal audit programme which Doriann confirmed. **Action: Policy to be amended accordingly.**

OUTCOME: The Committee **APPROVED** the updated CQC and Compliance Group Terms of Reference subject to the changes described above.

09/21 INAPPROPRIATE ACCESS TO CLINICAL RECORDS REPORT AND ACTION PLAN

The Managing Director of Digital Health presented the factfinding report and action plan and shared the presentation presented at Board on 14 January 2021. This piece of work started in September 2020 and is a work in progress. The first draft was presented at the Digital Health Forum in December 2020 for comment. Additional work has taken place to understand what the Trust deemed as inappropriate access to clinical records, which was retitled to access to clinical records. The report has been reviewed by the Communication Team and Assistant Director of Patient Experience and will be presented at the Board of Directors on 4 March 2021.

The Managing Director of Digital Health updated all Executive Directors on 7 January 2021 regarding the factfinding report, communications, and process. The report, currently

version 7, has 13 recommendations described in the action plan which are making good progress.

The actions include the development of an in-house alerting solution to identify any inappropriate access. An audit plan has been developed, policies are under review and a learning document is being developed to aid communication with the patient experience team. A further update will be presented to the Digital Health Forum on 18th February 2021 for approval prior to the Board in March 2021. Consideration is also being made on how this is introduced into Divisional Patient Safety Quality Boards.

RH asked if a disciplinary process is in place and if appropriate steps are being taken from a HR point of view. The Managing Director for Digital Health confirmed the Director of Workforce and OD is part of the panel and the final report will include a flowchart to describe how and when an incident is reported before it goes to HR.

RH noted from the report the automated tools such as 'Lights On' is not used to full capacity and asked if this is part of an alert solution. The Managing Director for Digital Health confirmed the 'Lights On' solution is part of EPR Cerner; however, patient data is also in Athena (Maternity notes), Medisoft and other systems and the Trust need to ensure all records are captured. The 'Lights On' tool shows activity within EPR and a training session with the Information Governance team is taking place week commencing 8th February to see if this can be utilised for the audits. An alerting tool has also been developed through the Knowledge Portal which highlights when unusual access takes place. The Trust are also reviewing off the shelf systems as well as in house systems to strengthen audit activity DS asked how soon the audits will be in place. The Managing Director for Digital Health confirmed they are ready now and have been tested with parameters set by the Information Governance team. The audits will go live following a demonstration at the Digital Health Forum in February.

The Company Secretary pointed out the action plan 7.8 details a risk scoring 12 on the corporate risk register and asked which risk register this presented on. The Managing Director for Digital Health confirmed this is the Trust wide risk register.

AN asked where the action plan will be monitored. The Managing Director for Digital Health confirmed this is a standing item at the Information Governance and Records Strategy Group and any escalation will be brought to the Audit and Risk Committee, with a further update to the Board in 6 months.

OUTCOME: The Committee **NOTED** the update on inappropriate access to clinical records and the action plan.

10/21 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 quarter which shows the usual trends.

The risk of loss of personal effects has increased during the Covid-19 period due to the visiting restrictions in place and more valuables being on Trust sites. This risk will be reviewed going into quarter 4.

AN asked if the losses other of £48.6k is correct. The Deputy Director of Finance confirmed this number refers to the year to date total and some numbers refer to in quarter.

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

2. Review of Waiving of Standard Orders

The Deputy Director of Finance presented a report on the Trust's waiving of standing orders showing the overall total in the quarter has significantly reduced since the first half of the year. In the quarter, there was a total of £288k waiving of standard orders, in the context of £17m worth of spend. An additional appendix has been included since quarter 3 which describes a long list of items related to Covid. The volume of these have reduced considerably since the numbers have been brought into the report. The Deputy Director of Finance confirmed there is now an effective route for purchasing PPE which is via allocations from national purchasing reducing the need for purchasing by the Trust.

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

3. Update of Treasury Management Policy

The Deputy Director of Finance presented the updated Treasury Management Policy the review of which has been brought forward considering the significantly different cash and borrowing position. The proposed changes to the existing policy are highlighted in the cover sheet.

RH stated section 4.2 still refers to Monitor and asked if this should be changed to be more current. The Deputy Director of Finance confirmed Monitor is referred to twice in the policy, the awarding of the licence was by Monitor and a new license hasn't been received and the treasury management guidance was also issued by Monitor and remains the latest national document. It was clarified that Monitor is the correct wording. RH asked if the policy could state 'Monitor, now known as NHSI', this was agreed.
Action: Deputy Director of Finance

RH explained that the Trust can invest surplus monies on deposit; however, the Trust would receive less interest by doing this. The Trust pay a PDC charge of 3.5%, this is reduced by our cash holdings. The Deputy Director of Finance explained the Trust would do this if the interest was more than 3.5% on a safe harbour investment. The Deputy Director of Finance has reviewed the policy and is confident the wording of the policy acknowledges the need to balance out the benefit of PDC versus the benefit of investment.

OUTCOME: The Committee **APPROVED** the updates to the Treasury Management Policy subject to the change noted above.

11/21 REVIEW OF STANDING ORDERS, STANDING FINANCIAL INSTRUCTIONS, SCHEME OF DELEGATION

The Deputy Director of Finance explained the policies have been reviewed considering the reference to the European Union within the documents. All changes made are detailed in the front sheets with no radical changes.

Standing Orders

AN raised Monitor is referred to on page 1 under section 1.1.3. The Company Secretary and Deputy Director of Finance have discussed this and the NHSI website also refers to the Monitor Code of Governance; therefore, this will remain unchanged.

AN highlighted non-compliance with standing orders goes to the Board of Directors and suggested this also goes to the Audit and Risk Committee. The Company Secretary confirmed both should be referenced and it will depend on which meeting falls first.
Action: Company Secretary to add the Audit and Risk Committee to the Overriding Standing Orders Section 3.4

Action: Company Secretary to remove blank page 11 in the document

Standing Financial Instructions
AN highlighted section 3.4.1 on page 12 refers to chapter 11, which should be corrected to chapter 12 in the document. **Action: Deputy Director of Finance to update the chapters and reference numbers in the SFIs**

AN suggested the loss of special payments register on page 39 should mention the role of the Audit and Risk Committee (paragraph 14.2.7). The Deputy Director of Finance confirmed it is referenced in an appendix; however, this will also be made clear within the document. **Action**

Scheme of Delegation
The Company Secretary reported the updates include the name of a Committee and the Covid related changes as previously agreed by the Audit and Risk Committee.

RH asked for assurance that approval levels haven't changed and are as previously agreed. The Deputy Director of Finance confirmed there have been no changes to the standard approval levels. The exceptions to this are highlighted in the separate Covid addendum to the policy which are Covid related and were agreed by the Audit and Risk Committee on 21 October 2020. This addendum will be withdrawn separately to the policy review dates.

AN highlighted there were two versions of the Covid-19 addendum, one separate document at the end of the polices and one attached to the cover sheet. The Deputy Director of Finance confirmed the document was tagged onto the cover sheet in error and the second version is correct as the capital expenditure limits were removed as NHSI had changed their guidance in the way Trusts can approve capital expenditure.

Doriann stated the job title 'Assistant Director for Quality and Safety' should be updated to 'Assistant Director for Patient Safety' in Appendix 2 on page 49. **Action**

OUTCOME: The Committee **APPROVED** the updates to the Standing Orders, Standing Financial Instructions and Scheme of Delegation and the extension of the temporary addendum to the Standing Financial Instructions and Scheme of Delegation subject to the changes noted above.

12/21 INTERNAL AUDIT

Internal Audit Follow Up Report
Kim Betts, Interim Internal Audit Manager for Audit Yorkshire explained the process for update requests on recommendations had been slightly different this month. The request for information was sent out late as the figures were asked to be reviewed which took longer than anticipated. At present, there is one outstanding response on governance in the Medical Division. The other recommendation dates have been moved forward and the Interim Internal Audit Manager will share an up to date table by the end of the week.

The main concern in overdue major recommendations is the death certificates audit. A response was received from the Medical Examiner acknowledging there has been some delay in progressing this service with the aim to produce the draft policy and KPIs in the next few weeks. This audit is on this year's plan.

The Interim Internal Audit Manager explained dates have been reviewed and it has been agreed the 'not yet due' dates now show as 'overdue', which is presented in table 2 on

page 4. She added the job plan recommendations remain as outstanding and two actions are sitting on the report which Leanne Sobatree will review and correct accordingly.

The Interim Internal Audit Manager explained the MK Insight system is used by most clients for all planning, fieldwork and tracking of recommendations. It was highlighted that this system will fill a process gap. The system can also produce reports as required.

The Director of Finance provided an update on the car parking recommendation which will continue to be outstanding as a decision was taken at the Weekly Executive Board meeting last week to not revise this policy given the sensitivity for staff at present. The actual policy review date has been extended by 6 months.

The Deputy Director of Finance agreed it is important to implement this system as a route to confirm progression of recommended actions and suggested a prompt to recommendation owners would be helpful. The Head of Internal Audit confirmed the MKI system has an automatic email reminder which escalates to the audit team and audit responder. This Committee agreed that the implementation of this system for the Trust should be progressed as a priority. RH welcomed adopting the MKI Insight system which will provide improved information and processes.

RH suggested each responsible Director should continue to receive a report on overdue recommendations and if necessary, should be asked to appear at the Committee to report on progress of their actions.

DS asked if the outstanding recommendations from the Audit Programme report into the weekly Executive Board. The Managing Director for Digital Health and Deputy Director of Finance explained the Audit Yorkshire Programme is reviewed at the Executive Board by exception and this relies on a manual system. It was suggested consideration be given to more regular reporting at the Executive Board. The Internal Audit Plan is also shared with the Executive Board routinely on an annual basis.

Internal Audit Progress Report
The Interim Internal Audit Manager presented the Progress Report and reported that five audit reports have been issued since the last meeting of the Committee: two with limited assurance, two significant and one high opinion report.

The Interim Internal Audit Manager confirmed Audit Yorkshire have sufficient resources to complete the plans with currently seven people working on the Trust audit plan. The audit on Identify Access and Management is to be put on hold until mid-February as members of the team have been affected by Covid resulting in additional pressures to support completion. It is expected that these audits can be completed. The Data Security and Protection toolkit, which was delayed nationally, will be progressed. Quarter 4 audits are being planned e.g. models of new care and pathways to the new hospital.

AN acknowledged that the core audits informing the Head of Internal Opinion will be completed however other audits are likely to be deferred. The Head of Internal Audit re-assured the Committee that managers have populated the must-do and should-do pieces of work through the year, priority areas are identified, and the internal audit team are sighted on the key risks. A piece of work has been undertaken to review the governance arrangements during Covid, including financial governance and how Covid has impacted on the Trust, e.g. how decision making has been impacted, which will inform the annual governance statement. The Head of Internal Audit is optimistic that all must do and should do audits will be completed by the end of April; however, completion dates for some audits may move to the middle of June. RH reported there was a desire by the

HPS Board to complete the audit on HPS by the end of the year which was previously on hold due to a software upgrade.

OUTCOME: The Committee **NOTED** the Internal Audit Follow Up Report and Progress Reports and **RECEIVED** the limited assurance reports and the Insight report for December 2020.

13/21 LOCAL COUNTER FRAUD PROGRESS REPORT

Steve Moss, Head of Anti-Crime Services presented the Counter Fraud Progress Report. The table in the report details how many days have been completed versus the planned areas. The team are light on 'inform and involve' days due to Covid restrictions as awareness work is not taking place on Trust sites and referrals with clients has reduced which is a national trend. Newsletters and alerts are happening virtually, and meetings are being arranged via Microsoft Teams.

The Head of Anti-Crime Services informed the Committee that Shaun Fleming has been allocated to support the Trust moving forward as the Local Counter Fraud Specialist.

The Deputy Director of Finance highlighted counter fraud education is part of the Trust Leadership package in 'Managing our Money' training and there are more routes than Audit Yorkshire training to promote this message.

AN asked for an update on the government functional standards piece of work. The Head of Anti-Crime Services explained these are due to come out in early February and he will share the new standards and explain what has changed from the existing ones. The Audit and Risk Committee will review any changes.

OUTCOME: The Committee **RECEIVED** the Local Counter Fraud Progress Report and **NOTED** the new government functional standards will be received shortly.

14/21 EXTERNAL AUDIT SECTOR UPDATE

Agree External Audit Plan for 2020/21

Clare Partridge, External Audit Partner reported a meeting took place with the finance team on 26 January to discuss this plan. The funding will be reviewed at year end and be reflected accurately as things change.

The External Audit Partner highlighted the significant risks being focused on are the valuation of land and buildings, revenue recognitions, management override of control and fraudulent expenditure recognition.

The External Audit Partner highlighted stock counts are material for financial statements and the subsidiary in terms of pharmacy stock and are planned to take place remotely via video due to Covid. The stock counts last took place in February last year prior to the lockdown. All stock counts will now take place remotely unless it is business critical.

The External Audit Partner explained the value for money test is adopting a new process and approach for this year. Previously, a deep dive may take place for any area where significant risk is identified; however, the risk assessment stage now includes a raft of procedures. An update on the risk assessment phase will be provided at the next meeting. Value for money is reported separately with the findings in a publicly available report and will require a close narrative with the Trust to ensure these are aligned.

The audit opinion has a slight change arising from auditing standards this year, which includes the requirement to report any breaches of laws and regulations. External Audit

are considering what this means for license conditions in terms of the value for money and what this means for opinions.

The External Audit Partner pointed out there are two fees tables in the report and the second one is correct and has already been approved.

RH stated the audit plan is consistent with previous years. He is interested to learn more about the value for money assessment which may link into the Use of Resources assessment. The Finance and Performance Committee have been looking at ways to assess performance on Use of Resources.

RH asked if there will there be more work regarding the Going Concern assessment this year because of new requirements. The External Audit Partner explained the auditing standards will require more audit work and this will link with work on the Use of Resources assessment.

OUTCOME: The Committee **APPROVED** the External Audit Plan for 2020/21, **RECEIVED** the sector update and PFR Benchmarking Report Q2 20/21.

15/21 COMPANY SECRETARY'S BUSINESS

Annual Report and Accounts Timeline 2020/21

The Company Secretary explained the Foundation Trusts annual reporting manual and timetable has not yet been received and a draft timetable for this year's annual report and accounts has been shared based on discussions with Zoe Quarmby and KPMG. The key dates confirmed are 27 April 2021 for the draft accounts and 15 June 2021 for submission of the audit accounts. The External Audit Partner explained there is the possibility for Trusts to apply for later dates; however, CHFT is sticking to the usual timeframe. The timetable will be updated when the national annual reporting manual is received. The annual report and accounts will need to be signed off the week commencing 7th June 2021. The Committee and the Board will need to discuss sign-off arrangements, either by the Board or through delegation to the Audit and Risk Committee.

The Company Secretary explained the quality accounts are no longer part of the annual reporting process and more information on quality will be within the performance report in the accounts.

Conflicts of Interest and Standards of Business Conduct Policy

The updated conflicts of interest and standards of business conduct policy was shared with changes highlighted in red.

Self-Assessment of Committee Effectiveness

All Committee members are asked to complete the self-effectiveness checklists and return them by 12 February 2021. The Committee will approve an action plan at the next meeting.

Audit and Risk Committee Workplan 2021

The Audit and Risk Committee Workplan for 2021 was shared for approval.

Review Audit and Risk Committee Dates

The Audit and Risk Committee dates for 2021 were shared for information.

OUTCOME: The Committee **RECEIVED** an update on the Annual Report and Accounts timeline 2020/21, **APPROVED** the updated Conflicts of Interest and Standards of Business Conduct Policy and Annual Workplan for 2021 and **NOTED** the schedule of

meeting dates for 2021 and that their responses to the self-assessment checklists of committee effectiveness are to be submitted by 12 February 2021.

16/21 REVIEW OF BOARD ASSURANCE FRAMEWORK

The Company Secretary presented an update to the Board Assurance Framework (BAF), which is the third and final update this financial year which links to the Head of Internal audit opinion.

There are two updates outstanding on risks (6/19) on climate change and (10b) medical staffing. The Company Secretary will ensure these are followed up and added into the BAF for March Board. AN explained an update was provided at the Green Planning Committee on climate change.

The (9/19) estates risk has been reviewed by the lead Directors with no change. The lead for the Covid capacity risk (5/20) is still being discussed to understand if this sits under Finance and Performance and this will be discussed at the Finance and Performance Committee.

AN asked if the 3 of 4 workforce risks categorised as a risk appetite category of quality and innovation is correct or whether these should be allocated a workforce risk appetite category which has a low risk appetite. The Company Secretary will review using the same principle as risk 12/19 and take to the Workforce Committee for discussion. **Action: Company Secretary**

RH explained risk 08/19 on performance targets was not updated at the last Finance and Performance meeting; however, there is no change expected. The Company Secretary confirmed the Chief Operating Officer has sent through an update; however, acknowledged no Committee review took place.

RH flagged up the allocation of risks across various committees is a concern and needs to be agreed between the Non-Executive Directors. The Company Secretary will provide the current allocation of the BAF risks to the Non-Executive Directors for consideration and review. **Action: Company Secretary**

Richard Hill, Head of Health and Safety provided an update on the health and safety risk on the BAF. He highlighted the five-year strategy looks at NHS safety standards and is used by many other NHS Trusts and the plan is to introduce these standards at the next Health and Safety Committee on 20 February 2021. There are roughly 35 standards and updates will be provided as progress is made.

It was noted the Health and Safety Policy will come to the next Committee for approval.

OUTCOME: The Committee **APPROVED** the updates to the Health and Safety Risk 16/19 and the Board Assurance Framework.

17/21 HEALTH AND SAFETY COMMITTEE TERMS OF REFERENCE

The Head of Health and Safety presented the updated Health and Safety Committee terms of reference. He explained sub-groups will be set up to bring regular reports into the Health and Safety Committee. The Committee will focus on the top four risks.

AN suggested the wording regular updates is changed to quarterly updates on page 3 under duties. **Action: Head of Health and Safety**

AN felt the escalation of risks of a score 9 more was a low threshold and explained only high-level risks are reported to the Audit and Risk Committee. The Company Secretary

explained the escalation route should reflect the Risk Management Strategy and report through the Risk Group in their reports. **Action: Head of Health and Safety**

AN explained the duties of the Committee does not reference developing the five-year strategy. **Action: Head of Health and Safety**

AN highlighted the Risk and Audit Committee needs to change to Audit and Risk Committee on page 6. **Action: Head of Health and Safety**

OUTCOME: The Committee **APPROVED** the Health and Safety Committee terms of reference subject to the changes above.

18/21 SUMMARY REPORTS AND MINUTES TO RECEIVE

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

- Risk Group (Formerly Risk and Compliance Group) – no questions were raised.
- Information Governance and Records Strategy Group
  RH asked for an update on compliance with the DSP Toolkit, reported at 92% for training. The Managing Director for Digital Health is confident the compliance target of 95% will be reached by the extended date of June 2021. The 92% for training is an improvement; however, not where it needs to be. Implementation of the new password policy is underway and reporting on the 10 characteristics is updated at the Weekly Executive Board.
- Health and Safety Committee – no questions were raised.
- Data Quality Board – no questions were raised.

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

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

19/21 ANY OTHER BUSINESS

There was no other business.

20/21 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- Risk Management Deep Dive
- Approved revised Risk Management Strategy and Risk Group and CQC and Compliance Group terms of reference
- Internal Audit – more robust system in place to follow through using the MKI insight tool and confident sufficient audit work will be completed for a Head of Internal Audit Opinion to be provided
- Approved the Health and Safety Committee terms of reference
- Approved External Audit Plan for 2020/21

21/21 DATE AND TIME OF THE NEXT MEETING

Monday 12 April 2021
1:00 – 3:15 pm via Microsoft Teams

22/21 REVIEW OF MEETING

AN acknowledged it was a packed agenda with several additional items this month.
The meeting closed at 12:32 pm.

Calderdale and Huddersfield NHS Foundation Trust

DRAFT MINUTES OF THE FOUNDATION TRUST COUNCIL OF GOVERNORS MEETING HELD AT 3:30 PM ON THURSDAY 28 JANUARY 2021 VIA MICROSOFT TEAMS

PRESENT:

Philip Lewer	Chair

Public Elected Governors

John Gledhill	Public Elected – Lindley and the Valleys
Christine Mills	Public Elected - Huddersfield Central
Annette Bell	Public Elected – East Halifax and Bradford
Stephen Baines	Public Elected – Skircoat and Lower Calder Valley - Lead Governor
Alison Schofield	Public Elected – North and Central Halifax
Jude Goddard	Public Elected – Calder and Ryburn Valleys
Veronica Woollin	Public Elected - North Kirklees
Sheila Taylor	Public Elected – Huddersfield Central
Lynn Moore	Public Elected - North and Central Halifax

Staff Elected Governors

Linzi Smith	Staff Elected – Management / Admin / Clerical
Sally Robertshaw	Staff Elected – AHPs
Peter Bamber	Staff Elected – Doctors/Dentists

Appointed Governors

Cllr Lesley Warner	Kirklees Metropolitan Council
Prof Joanne Garside	University of Huddersfield
Chris Reeve	Locala
Cllr Megan Swift	Calderdale Metropolitan Council

IN ATTENDANCE:

Alastair Graham	Non-Executive Director
Karen Heaton	Non-Executive Director
Gary Boothby	Director of Finance
Helen Barker	Chief Operating Officer
Doriann Bailey	Assistant Director of Patient Safety
Gareth Webb	Senior Manager, Quality and Safety
Owen Williams	Chief Executive
David Birkenhead	Medical Director
Andrea McCourt	Company Secretary
Amber Fox	Corporate Governance Manager (minutes)

01/21 APOLOGIES FOR ABSENCE

Salma Yasmeen - South West Yorkshire Partnership Foundation Trust
Ellen Armistead - Director of Nursing
Helen Hunter - Healthwatch – Kirklees and Calderdale

02/21 WELCOME & INTRODUCTIONS

The Chair welcomed governors, colleagues from the Board of Directors and staff presenting papers to the meeting.

03/21 DECLARATIONS OF INTEREST

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

04/21 MINUTES OF THE LAST MEETING HELD ON 22 OCTOBER 2020

The minutes of the previous meeting held on 22 October 2020 were approved as a correct record.

The Chair highlighted Jude Goddard and Alastair Graham have recently featured as guest editor in the Trust weekly newsletter to express thanks to staff. If any governor is interested in participating and featuring in the newsletter to please let us know by emailing councilofgovernors@cht.nhs.uk.

OUTCOME: The minutes of the previous meeting held on 22 October 2020 were **APPROVED** as a correct record.

05/21 MATTERS ARISING / ACTION LOG

The action log was reviewed and updated.

OUTCOME: The Council of Governors **NOTED** the updates to the action log.

06/21 FEEDBACK FROM NON-EXECUTIVE DIRECTORS IN ATTENDANCE – KAREN HEATON AND ALASTAIR GRAHAM

The Chair invited Karen Heaton and Alastair Graham to share their background and an update of what they have been involved in with the Trust.

Karen Heaton, Non-Executive Director provided an update on all the work she has been involved with in the Trust. KH is Chair of the Workforce Committee and has been on the Board for five years. By background, KH is the Director of Human Resources for the University of Manchester.

KH provided an update on the Workforce Committee agenda which has seen a focus on Health and Wellbeing, a deep dive into workforce data which identifies concern regarding the increasing level of staff sickness absence which remains under scrutiny. There have been deep dives into the recruitment process, which has seen some improvements, and the board assurance framework areas, largely around staffing. KH also attends AAC (Consultant) recruitment panels and explained a recent panel was successful in recruiting. She explained the competency framework for Non-Executive Directors is being reviewed with Peter Wilkinson to look at any improvements. KH is also a member of the Covid Oversight Group which is Chaired by Denise Sterling. KH also advised that she has volunteered to be the nominated Non-Executive Director for the Ockenden review about maternity services.

Linzi Smith asked if the Trust still offer a retire to return option for colleagues or if colleagues can re-join on a Bank or zero-hour contract. KH explained she would look into this; however, staff who had retired were approached to assist the Trust with the Covid pressures and vaccination programme. **Action: Chair to check this with**

Suzanne re: retired staff and zero hours contract and respond to Linzi outside of the meeting.

Alison Schofield raised a concern arising from the Disability Action Group to ensure that reasonable adjustments are made for staff working from home who are high risk. KH explained this should be addressed with their Human Resources partner and any reasonable adjustment should be the same to ensure staff have a safe as possible working environment from home.

Chris Reeve asked what opportunities the Trust have around the workforce agenda. KH highlighted there are great opportunities for hybrid working and explained how quickly staff have adapted in the use of technology. She added there may also be an impact on the estate, such as how much of it is needed if staff are working from home and the impact on the carbon footprint with less work-related travel.

Annette Bell asked for a definition of hybrid working. KH explained hybrid working is a mix of working from home and working in the workplace, a form of flexible working.

Cllr Lesley Warner asked if there is a national view to lead a campaign in response to increased staffing absence and ongoing demanding work, such as bursaries. KH explained this is a national advert and would like to think the bursaries would be re-introduced. The government are trying to progress apprentices and careers inside the NHS.

Peter Bamber felt that staff who are working from home due to Covid should be able to make claims for keeping their house warm in winter. KH responded to explain such staff have reduced travel costs and confirmed home working staff can claim tax relief from HMRC for heating and lighting expenses.

Alastair Graham, Non-Executive Director has been on the Board for just over three years. AG was previously Managing Director for the National Housing Association and prior to this he ran a major Regeneration Programme across parts of Greater Manchester. Alastair's background is in local government and housing estate matters. AG is the Chair of Calderdale and Huddersfield Solutions Limited (CHS) which provides estate and facilities, particularly to Huddersfield Royal Infirmary. CHS also provides procurement services across the whole Trust, portering services, cleaning services and materials management. The role of CHS during the pandemic has been important in making sure there is enough PPE, medical equipment, refrigerators for vaccines and isolation facilities. A new isolation facility was created in record time by CHS and handed over to the hospital in December 2020. AG also has the privilege of being a member of the Research and Innovation Committee and explained the research team played an important role on the recovery trial which is a national trial looking at treatments for Covid. He explained more patients were recruited into this trial than almost any other Trust regionally and nationally. The Trust were involved in helping discover a drug called Dexamethasone and saving lives nationally and internationally. This research work has attracted interest nationally and internationally which is very positive. AG also attends the Transformation Programme Board, Chaired by Peter Wilkinson. The plans for reconfiguration are continuing to progress at pace in terms of the reconfiguration of the two hospitals, following approval of the £196b subject to an outline business case, detailed business case and planning permission. The Trust are very shortly going out to consultation with plans for Calderdale, which will then go for planning

permission in May 2021. The HRI works is also progressing for a new Emergency Department towards the back end of the current year and work is starting at CRH next year which includes a new multi-story car park. AG also attends AAC panels for recruitment and explained it is heartening to see individuals that really want to join the Trust.

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

07/21 Quality Report Presentation

Doriann Bailey, Assistant Director for Patient Safety shared a presentation which focused on quality priorities for 2020/21, complaints, governance and the Ockenden maternity review.

Doriann updated the governors on the progress that has been made on the three quality account priorities selected by the Council of Governors last year which were included in the presentation.

Doriann presented an update on the quality governance agenda during the Covid pandemic. The Quality Committee meetings continue to take place; however, one meeting was stood down due to the pressures within the clinical workforce and these agenda items were addressed in subsequent meetings. Lots of work has taken place to streamline the agendas and the Divisional Patient Safety Quality Board meetings have all continued. The high-level risk register is received and reviewed at each meeting and key risks have undergone deep dives to provide greater assurance. The governance structure has been revised under the Trust Patient Safety Quality Board and Quality Committee to ensure robust reporting is taking place. The Risk Register and the Risk Management Strategy has been reviewed.

Doriann provided an overview of complaints and explained the Director for Patient Experience has reviewed the complaints process against the PHSO standards. Work has also taken place to develop an approach to learning from complaints and incidents utilising an online portal; however, there are financial challenges of taking this forward which is under review. Work is taking place to develop the Datix dashboard for reporting of complaints. Divisional level support has been offered for the management of complaints and work has taken place to fill vacancies in the complaints team and there is now a full complement of staff. Doriann reported there was a national pause of complaints during the Covid-19 pandemic and shared a chart detailing the number of complaints received during the pause period and after. The Trust are seeing a reduction in re-opened complaints.

The Ockenden review was published on 10th December 2020 which presents the findings on an independent review of Maternity Services at Shrewsbury and Telford Hospital NHS Trust between the period of 2000 and 2019. The Trust have been asked to submit a position statement against 7 key actions and 12 safety priorities. CHFT's response demonstrates compliance in all these areas. The key actions will be monitored through the Quality Committee. Karen Heaton, Non-Executive Director is the Maternity Safety Champion.

Linzi Smith asked if staffing comes up on the Ockenden review under safety due to the lack of midwives. Doriann responded to confirm assurances on all actions were

provided to the LMS, Local Maternity Services and she is not confident whether staffing was one of the key actions.

Peter Bamber asked if the governors can see a copy of the report which shows the Trust's compliance with the Ockenden report. Doriann will discuss this with Karen Spencer and provide a response to the Chair. **Action: Doriann to discuss sharing the Ockenden report with Karen Spencer and confirm the outcome with the Chair**

Christine Mills explained a lesson learned from a previous Quality Committee meeting was she didn't receive the papers for the Quality Committee with the Trust using an electronic system for papers for meetings. Michelle Augustine will ensure Christine receives the papers.

The Chair thanked Doriann Bailey for her update and presentation.

OUTCOME: The Council of Governors **NOTED** the Quality Report.

08/21 Selection of 2021/22 Quality Priorities

The Company Secretary explained the Trust are in the process of selecting next year's quality account priorities. The shortlist of six was agreed at the workshop in December 2020 and the governors are now asked to vote for one per category by 19th February 2020 which is the final stage of selection. This will be detailed in the Foundation Newsletter next week. Historically there has been a low response; therefore, the governors are asked to raise awareness with members of the process of selection and encourage response. The final selection will be confirmed at the Council of Governors meeting on 22 April 2021 and the priorities selected will be progressed throughout the year.

Chris Reeve asked if there are any metrics, for example, how much the Trust are looking to reduce these or if it is a general direction of travel. The Company Secretary confirmed the newsletter will include more information on each priority and once the final three topics are confirmed the metrics will then be worked through as a measurable improvement.

OUTCOME: The Council of Governors **NOTED** voting on the quality priorities for 2021/22 is to be submitted online by 19th February 2021 and are asked to encourage members to respond.

09/21 Risk Management Update Presentation

Gareth Webb, Senior Manager for Quality and Safety shared a presentation which focused on the Risk Management Strategy and Policy, risk governance and Covid-19 risk management.

The Risk Management Policy and Strategy has undergone a review and combined into one document. This was approved at the Audit and Risk Committee and will be presented to the Board for approval on 4 March 2021.

Gareth explained there is a Covid risk management team that meet daily. The current Covid-19 risk themes are described below:

- Isolation / Social Distancing – Isolating Covid wards from non-Covid wards and maintaining social distancing

- Delays – Non-Covid services, wards and theatres are being used for Covid or to isolate from Covid wards
- Capacity – Relating to staffing, Covid involves intense staffing 24/7 and individuals may be isolating or Covid positive which leaves a pressure on Covid clinical staff, health and wellbeing and support is being provided

Jude Goddard asked Gareth what the biggest impact has been in pulling the report together. Gareth explained he attends the Incident Management Team meetings from a risk perspective and noticed how professional staff continue to work under such difficult circumstances.

OUTCOME: The Council of Governors **NOTED** the Risk Management update.

PERFORMANCE AND STRATEGY
Covid-19 Vaccine Uptake by Trust, Division and Ethnicity
The Chief Executive presented an update on vaccinations by Trust which was requested by the Chair following a question from a governor via the informal meeting of the Council of Governors.

The Chief Executive reported the Trust have acted as a Community Hub and have vaccinated just under 15,000 people which ranges from CHFT staff, other healthcare workers and is in line with the prioritisation set out nationally. He added the Trust have had more focus on care home workers, health care workers and the Primary Care Network Partners have had a broader focus on community.

A total number of 4,137 Trust staff have been vaccinated to date which equates to 68.4%. The Chief Executive reported no second doses have been given out to date which falls in line with the guidance provided, which has moved from a 21 day to a 12-week window. This change has caused some concern amongst some colleagues and beyond CHFT, who were expecting a second dose within the original timeline. The Trust are ensuring no vaccine goes to waste which has taken a role in vaccinating as many staff as possible.

There is focus on increasing staff vaccinations for staff in the Health Informatics Service, particularly staff who are still required to provide desk support.

Details of vaccinations given by ethnicity and Division were shared in the meeting.

Peter Bamber thanked the Chief Executive for his presentation and is delighted with the achievement on each site. Peter raised concern in poor uptake in certain ethnic groups mainly for medical reasons and asked how the Trust are reaching out to the groups who are more reluctant. The Chief Executive explained the Trust are using a modelling approach to advocate take up of the vaccine and are working hard to recognise any cultural concerns. Any concerns in having the vaccine will have a wider impact in the community.

Annette Bell asked if the Trust are approaching younger people. The Chief Executive responded to confirm the criteria set out is to prioritise the elderly following national guidance; however, the younger groups are still being targeted.

The Chair explained he is very impressed with the Covid-19 Vaccination Programme. The Chair thanked the Chief Executive, Medical Director and Mel Addy who is

operationally managing the vaccination programme for their hard work and professionalism running this service 7-days a week. The Medical Director is also involved in the work at John Smiths Stadium.

10/21 Operational Update

The Chief Operating Officer provided an update on the current Covid-19 position as at 28th January 2021.

The key updates were:

- 45,044 patients were tested with 1,173 testing positive
- 141 current inpatients with a positive Covid test
- Small number with a negative test who are showing clinical signs of Covid and are treated as though they have Covid
- 453 patients have died, 29 in the last week
- Important to note lots of patients do get well post Covid
- Staff absence is increasing
- Wave 3 is showing more of a peak than wave 1 and 2

The Chief Operating Officer shared some national key messages which were included in the presentation.

The Chief Operating Officer confirmed plans are in place for Covid changes and a new isolation facility has been opened at Ward 18, Huddersfield Royal Infirmary. She thanked CHS colleagues for opening this facility in record time. Patient flow has improved, and A&E waiting times have reduced. She explained all diagnostics except Endoscopy will be at 6 weeks maximum by the end of March 2021. The Chief Operating Officer shared a positive message in that cancer pathways have been maintained at pre-Covid timelines.

The Chief Operating Officer explained backlogs and prioritisation is a focus at the next Board Development Session on 4 February 2021.

11/21 Performance Update

The Chief Operating Officer provided an update on current performance. There has been a slight dip in the overall performance percentage which relates to Trust backlogs; however, generally the Trust are holding a good position. There has been an improvement in the number of patients that arrive at A&E with a query stroke. There is some concern regarding long-term sickness which has started to increase slightly which is being monitored by the Director of Workforce and Organisational Development.

The Chief Operating Officer explained there was an investment into the frailty service two years ago which has continued for this year. Last year, just short of 950 patients attended A&E who were classed as frail patients with 46% (433) admitted. This December, 904 patients attended A&E with only 28% (256) admitted. This is a big improvement saving over 1,300 bed days in the month with no increase in re-admission rates.

The Chair thanked the Chief Operating Officer for her presentations which will be shared with the governors following the meeting.

OUTCOME: The Council of Governors **NOTED** the Covid-19 vaccination update and uptake by division and ethnicity, the Operational Update and Performance Update.

12/21 Financial Position and Forecast – Month 8

The Director of Finance summarised the key points in the finance report for the period ending November 2020.

The Trust were in a position up to the end of September 2020 where all reasonable costs were being re-imbursed; however, the Trust has submitted a plan identifying performance for the last six months of the year which shows the Trust ahead of plan and underspent by £1.1m at month 8. This underspend is predominately due to difficulties recruiting staff. The plan had set strict criteria with a requirement to assume certain levels of additional activity e.g. elective; however, due to the high level of Covid activity, the Trust have not been able to do this. The underspend is being driven by consumables (theatres) and staffing not required to deliver more elective activity.

The report highlights a potential risk at month 8 in relation to the elective incentive scheme. This is where funding provided would be reduced based on the level of elective activity the Trust can undertake. The Trust have been unable to achieve the level of elective activity set out this year; however, since the publication of the report the rules have changed and there will be no penalty incurred if the level of Covid activity exceeded 15% of bed base which it has.

Year to date the Trust has spent nearly £21M related to Covid, for example on PPE and additional staffing.

The Trust are forecasting to deliver the plan; however, it is still a deficit plan with a plan to be overspent by £1.9M as agreed with West Yorkshire Integrated Care System (ICS).

In terms of forecast for the year, by year end the Trust are forecasting to spend an additional £37m over and above the plan at the start of the year. This additional funding of £37m has been provided from NHS England/Improvement recognising the challenges of Covid.

OUTCOME: The Council of Governors **NOTED** the Month 8 Financial Summary for 2020/21.

13/21 Planning Overview 2021/22

The Director of Finance reported the Trust are not in a position at the current time to bring a proposed financial plan for governors' support. This is due to the challenges of Covid waves and uncertainly of what elective recovery activity is required. There has been a change to the position this year and the national planning guidance will now not be issued until April 2021 and Trust will have to submit plans by June 2021. The funding given for the latter half of this year will be rolled over for the first quarter of next year. This will provide more time to understand the position for next year and the government more time to agree the funding envelope with Treasury.

The Director of Finance explained that internally, the Trust still aim to create an internal plan ready for 1 April 2021 which will maintain budget holder accountability. The capital plan for this year has been agreed with a plan to spend £4.7M of internally generated funds. This has been agreed through the Board and a Dragon's Den process, where colleagues are asked to bid on capital allocation by considering bids and risk register ratings.

The Director of Finance explained there will be additional external capital funding this year for example digital, scan for safety and supported radiology and pathology programmes.

The Director of Finance reported the Trust will still be working within the Integrated Care System financial framework in the next quarter, with an allocation of funding.

There is some recognition that the Trust hasn't been able to deliver the efficiencies of the Cost Improvement Programme (CIP) this year which are recurrent efficiencies. There is also recognition the Trust have not been able to engage to understand the cost improvements for next year. Within the funding allocation nationally, this will be taken into consideration. The Director of Finance and Chief Executive have been discussing the efficiency challenge with the clinical teams, for example using opportunities such as 'Business Better than Usual', the opportunity to recover activity, eliminate waste and improve care.

The Director of Finance report a financial plan for next year will be brought back in another quarter.

OUTCOME: The Council of Governors **NOTED** the update on financial planning and a financial plan for next year will be brought back to a future meeting.

14/21 UPDATE FROM COUNCIL OF GOVERNORS SUB-COMMITTEE

Nominations and Remuneration Committee held on 18 January 2021

The Chair left the meeting at this point due to a conflict of interest relating to the re-appointment of Chair.

The Company Secretary reported the Chairs first term of office ends in March 2021. A Nominations and Remuneration Committee of the Council of Governors considered the Chair's re-appointment which reviewed several documents including the satisfactory outcome of the Chair's appraisal. The governors unanimously supported the Chair for re-appointment.

The Council of Governors were asked to ratify the decision made by the Nominations and Remuneration Committee held on 18 January 2021 which will be confirmed at the Board on 4 March 2021.

Stephen Baines as Lead Governor added he feels that Philip has been an excellent Chair of the Trust and is hopeful the governors will accept the recommendations from Nominations and Remuneration Committee which decision was unanimous.

The Council of Governors were unanimously in support of this decision for re-appointment of the Chair for a further term.

OUTCOME: The Council of Governors **SUPPORTED** the recommendation from the Nominations and Remuneration Committee meeting held on 18 January 2021 to support the re-appointment of the Trust Chair for a further term.

15/21 CHAIR'S REPORT

The Chair reminded governors if they are unable to attend meetings that they are allocated to if they could ask their deputy governor to attend. These meetings are where the governors can hold the Non-Executive Directors to account.

The Chair reminded governors of the informal Non-Executive Director and Governor workshop taking place on Thursday 11 February between 3:00 – 5:00 pm which will focus on the reconfiguration and the Integrated Care System (ICS).

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

GOVERNANCE

16/21 UPDATE FROM LEAD GOVERNOR/CHAIR

No further update.

17/21 COMPANY SECRETARY'S REPORT

a. Review of Election Arrangements 2021

The Company Secretary presented the paper which describes several governor vacancies for 2021 and the proposals for the elections this year. There are twelve public vacancies this year, three of which are governors coming to the end of their term and are eligible for a further three-year term. There are two governors who are eligible to stand for a further two-year term which leaves seven true vacancies to fill. There are four staff vacancies this year with one eligible to re-stand for a further term.

The Trust are now unable to use the reserve register following advice from NHS Providers that this is not an appropriate arrangement. The Trust will plan virtual engagement events and look to broaden diversity among groups in an effort to leave no vacant seats.

The full election timetable will be brought back to the meeting on 22nd April 2021.

Cllr Lesley Warner stated she feels the public don't understand that they can choose to become a member and asked if communication can be put out in the public domain about what becoming a member involves and asked for a copy of this to share. The Company Secretary confirmed there will be a communication strategy and acknowledged it is not a well-known role.

Lynn Moore suggested the invite to become a member or governor is advertised on the televisions around the hospitals. The Company Secretary will pick this up with the Membership Engagement Manager and Communications team.

b. Update of Tenures of Non-Executive Directors

The Company Secretary presented the paper describing the tenures of the Non-Executive Directors, for information. The Non-Executive Directors can serve two tenures for three years each.

Alastair Graham declared an interest in this agenda item.

OUTCOME: The Council of Governors **NOTED** the upcoming elections arrangements for 2021 and the update of tenures of Non-Executive Directors.

18/21 RECEIPT OF MINUTES FROM SUB-COMMITTEES

Minutes of the following meetings were received:

- Quality Committee meetings held on 28.9.20, 26.10.20, 30.12.20
- Workforce Committee meeting held on 19.10.20, 16.11.20, 9.12.20
- Charitable Funds Committee meetings held on 25.11.20
- Audit & Risk Committee meetings held on 21.10.20
- Finance & Performance Committee Meetings held on 2.11.20, 30.11.20
- Organ Donation Committee meeting held on 13.1.21

No questions were raised.

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

19/21 INFORMATION TO RECEIVE

a. Council of Governors Calendar 2021

The Council of Governor's calendar of meetings for 2020/2021 was circulated for information. This includes all governor meetings, workshops, and Divisional Reference Groups for 2021.

b. Updated Register of Council of Governors

The updated Register of Council of Governors as at January 2021 was circulated for information.

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

20/21 ANY OTHER BUSINESS

There was no other business.

DATE AND TIME OF NEXT MEETING

The Chair thanked the Council of Governors, Non-Executive Directors and Executive Directors for attending the meeting. The Chair formally closed the meeting at 17:32pm and invited governors to the next meeting.

Council of Governors Meeting

Date: Thursday 22 April 2021

Time: 3:30 – 5:30 pm (private meeting 2:00 – 3:15 pm)

Venue: Microsoft Teams

3. Items for Review Room

- CHS Managing Directors Update
- Council of Governors Election Timetable

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

FEBRUARY 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 Trust / CHS recently received monies addressing Capital Infrastructure Risk increasing the back-log maintenance to £4.6m. This includes demolition of the old nurses' home and learning centre subsequently reducing the back-log maintenance cost at HRI.

The team are now working with the recently procured principal supply chain partner (PSCP) Integrated Health Partnership (IHP) on all projects across HRI.

2.1.2 Community

Work to rationalise the estate footprint adjacent to HRI is now coming to an end. The disposal of Glen Acre House, Acre House Avenue and now Acre House is complete.

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 with programme end date forecast for Spring 2021.

2.1.4 Fire Safety

Fire safety remains an area of focus particularly at HRI. A draft copy of the HRI technical external audit by Motts has landed from which the Fire officer and Head of Estates are feeding back comments / queries.
The fire property review has now returned in draft which highlighted and overall level of good in terms of compliance albeit with actions to progress to excellent.
The actions are around, community fire door remediation, HRI 30 min compartmentation, fire plans and signage.
A draft trust Fire Strategy is now in circulation for comments and approval.

2.1.5 Portland Stone

The Portland stone cladding panels and windows remain a short and long-term risk at HRI, on-going maintenance and remediation continues to address the immediate risk, CHS estates are undertaking a process of due diligence to resolve the longer-term solution / replacement. This option includes over cladding the existing façade. Precedence has been set at Bristol Royal Infirmary while Aintree Hospital is currently completing the design stage and about to begin construction. Several “Go See” visits are being organised for members of the Trust to attend.

The Capital plan increase will begin to look at Pre-design investigations into the suitability of an over cladding solution. This will take place within Q4 of the Financial Year.

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.

Recent Nov 2020 Survey Previous position in May 2020

CLADDING CONDITION SUMMARY					
Elevation	Total score on matrix(NHS Estates codes)				Total No panels
	A	B	C	D	
1	0	724	88	0	812
2	0	188	23	0	211
3	0	416	69	0	485
4	0	186	25	0	211
5	0	544	33	0	577
6	0	185	46	0	231
7	0	443	5	0	448
8	0	148	8	0	156
9	0	70	46	0	116
10	0	396	58	0	454
11	0	528	30	0	558
12	0	117	104	0	221
13	0	194	37	0	231
14	0	197	43	0	240
15	0	174	25	0	199
16	0	413	71	0	484
17	0	764	94	0	858
18	0	312	23	0	335
19	0	446	254	0	700
20	0	70	22	0	92
21	0	908	68	0	976
22	0	424	76	1	501
23	0	377	27	0	404
24	0	22	0	0	22
25	0	56	1	0	57
26	0	65	3	0	68
27	0	158	7	0	165
28	0	178	0	0	178
29	0	171	4	0	175
30	0	167	12	0	179
31	0	659	70	0	729
32	0	409	15	0	424
33	0	67	0	0	67
34	0	104	6	0	110
35	0	64	4	0	68
36	0	540	34	0	574
TOTAL	0	10690	1394	1	11952

Table 1: Summary of cladding condition

CLADDING CONDITION SUMMARY					
Elevation	Total score on matrix(NHS Estates codes)				Total No panels
	A	B	C	D	
1	0	685	68	0	753
2	0	154	21	0	175
3	0	113	62	1	176
4	0	153	20	2	175
5	0	550	28	1	579
6	0	208	47	0	255
7	0	448	0	0	448
8	0	149	7	0	156
9	0	70	46	0	116
10	0	396	58	0	454
11	0	528	30	0	558
12	0	117	104	0	221
13	0	193	37	0	230
14	0	197	43	0	240
15	0	174	25	0	199
16	0	437	41	6	484
17*	0	765	93	0	858
18	0	317	18	0	335
19	0	446	254	0	700
20	0	70	22	0	92
21	0	908	63	5	976
22	0	425	73	3	501
23	0	377	27	0	404
24	0	22	0	0	22
25	0	56	1	0	57
26	0	65	3	0	68
27	0	158	7	0	165
28	0	178	0	0	178
29	0	171	4	0	175
30	0	167	12	0	179
31	0	659	64	6	729
32	0	408	16	0	424
33	0	67	0	0	67
34	0	104	6	0	110
35	0	64	4	0	68
36	0	540	34	0	574
	0	10346	1301	24	11901

Table 3.3.1: Appendix A -Summary of cladding condition

As can clearly be seen from the table above there is 1 stone cladding panel that has been classified as being significant enough to be classified as being D rating condition i.e. requiring immediate attention as soon as is practically possible.

In total there are 1394 panels or 11.66% that are classified as C condition rating utilising the NHS estates codes that are showing “significant signs of deterioration”. This could be due to the presence of any number of the following defects that require remediation repairs:

• exhibiting signs of minor movement.
• heavy water staining and missing grout,
• hairline cracks present to the face of the stone,
• damaged stone cladding panel
• several open drill holes to stone from historical scaffold fixings that have not been filled etc.
• exhibiting signs of minor movement.

2.1.6 Oxygen

The oxygen infrastructure became critical during the CV-19 peak in particular monitoring of the Vacuum Insulated Evaporator (VIE). Monitoring became twice daily and improvements were made during the peak which ensured the VIE operated as efficiently as possible. Demand peaked to 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

There is now 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 is due at IMT W/C 15th February.

2.2. Medical Engineering & Decontamination Service

2.2.1 Asset Tracking

Asset tracking system rollout complete in support of the COVID effort and it is working well.

Scan 4 Safety (S4S) funding for the expansion of the system to other assets throughout the Trust, delivered Dec 20 1,500 tags now being rolled out.

2.2.2 Active Temperature Monitoring

Medical Engineering have deployed the active temperature monitoring tags Trust wide, as a soft roll out communications and training are being prepared for New Year.

This project has now expanded to cover the Freezers for Covid Vaccine storage at –60 to –80°C tags fitted and active within one week of delivery in anticipation of vaccine delivery. It is noted that this is 2 freezers and due to the urgency of this training this has been rolled out to Pharmacy staff prior to the arrival of the vaccine.

Operational roll out for fridge training, for all relevant CHFT staff has been delayed due to current pressures and training requirement for staff, planned for before the end of FY to realise benefits for staff, this will however enhance CQC compliance for the Trust in any case as the evidence will be available.

2.2.3 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 as the National Loan equipment is rolled out Trust wide in support of the wave 2 Covid effort.

2.2.4 New Location for Medical Engineering

Expansion of Medical Engineering & Decontamination Service accommodation at HRI in order to facilitate social distancing and working differently under COVID and in the future, is in the planning phase with Estates, the first draft plans have been received, this will be essential to the continuation of service delivery for the Medical Device Training team, with the Learning Centre no longer being available. The Training Team have already made use of part of this space to deliver urgently needed training to staff.

2.2.5 Contract Management
Administrative team continue progressing well with contract renewals ahead of the busy New Year period, as procurement steps up towards the end of the Financial Year.

2.2.6 Decontamination and Repair of Mattresses
Currently planning to scope the possibility to deliver this service differently, plan to be presented to BoD in the New Year.

2.2.7 KPI compliance
We have again attained a Green compliance for all Risk levels this month and we are working to ensure that this position is maintained and improved in the coming months.

2.2.8 Vacancy
This month the post of Decontamination Manager will be advertised.

2.2.9 Student Placements
We now have two placements from Bradford University who will be working with us over the coming year, Hasnain Mir and Ammad Mahmood.

2.3. Facilities

2.3.1 Covid Support
Facilities services continue to support CHFT with additional porters, transport and cleaning. There are 3 x additional porters in place, in both the pool and ED, transportation of swabs, patients, equipment are still taking place and recent weeks has seen the Transport department providing support over 24hr periods to transport staff to and from work and to support out of hrs patient visits within the community, during the severe weather period. Additional cleaning is still in place to provide touch point cleaning and support on the acute floor and the department has recently been asked to provide hourly enhanced toilet touch point cleans; something which is proving challenging as in order to support requires a further 10 x domestics in post

2.3.2 Laundry Tender
The laundry tender is due to expire in June 2021 and as such the retendering process is well underway with final amendments being made to the documentation. A pre-marketing engagement session has been arranged to take place at the beginning of March for CHS to meet with potential providers.

2.3.3 Retail catering
CHS are currently exploring available options for bringing the retail and catering outlets back in house at HRI and Acre Mill. A recent “Go See” proved beneficial and colleagues who were on the visit found it gave a clear insight as to what successful looked like and what was required to become successful.

2.3.4 Transport services – CPC qualification
The Facilities manager of Transport has been successful in achieving his CPC (Certificate of Professional Competence) in PCV (Passenger Carrying Vehicle), which now means that CHS is able to apply for an Operator's licence, which will mean that the 3 x large shuttle buses will be able to operate again.

2.3.5 Out of hours hot vending trial

A few months ago, a decision was made to trial a hot vending provision so that staff would be able to access a hot meal 24/7. The trial ran for 3 months, following which a review was undertaken and recommendation made to the Trust to withdraw the service after findings showed that there was minimal uptake, with significant costs attached. The trial ended at the end of January and arrangements have been made for collection of the vending machines.

2.3.6 Staffing shortages

Several services have been impacted due to the number of staff either having to shield or self-isolate. Domestics services continue to see a significant reduction in the number of staff being in work and several vacancies which are proving harder to fill than in previous years. Because of this, there is a rolling advert out in the public domain and shortlisting / interviews are being undertaken on a weekly basis.

2.4. Procurement

2.4.1 Materials Management, Receipt and Distribution

The Materials Management team have worked under continuous pressure this quarter, delivering additional PPE services on behalf of the Trust such as the coordination of the lateral flow tests (Covid rapid tests) and providing additional PPE packs for the Covid injections. All of these services have been delivered in addition to ‘business as usual’ services, all of which have been maintained to a very high standard.

2.4.2 Category Management

End of year capital spend, and maintenance renewal season is consuming a significant amount of time within the team. There are also several tender exercises underway as well as support being provided for several long-term projects. FOI activity has also significantly increased which has been challenging to complete within the allocated time frames.

2.4.3 Operational Procurement

The Buying team have continued to support the Trust with their ongoing Covid requirements, along with maintaining a ‘business as usual’ service. The team have worked alongside Accounts Payable, to reduce invoice queries and improve and develop the invoice query process. The Covid service requirements include obtaining pricing and placing orders, along with being an active member of the PPE group. The team have worked on i-Proc hierarchy updates to improve the efficiency of the approval process. Other projects have continued to progress such as Scan4Safety which includes Inventory Management and Catalogue Management.

3.0 CHS

3.1. Spotlight Awards

Selwyn is a porter at Huddersfield and was nominated by Lee Sinnott, Facilities Manager, Porters & Linen Services, following the receipt of a Christmas card thanking Selwyn for his kindness to a patient. Selwyn was recognised for his act of providing excellent patient care by a member of the patient's family who took the time to track down Selwyn a year after the actual transfer to thank Selwyn for his kindness.

3.2. Finance

Year To Date Month 10

The year-to-date position is £0.46m surplus against a plan of £0.58m with a £0.12m adverse variance. The adverse variance of £0.12m results from the over recovery of income (£10.13m) due to additional goods and services being transacted through the company offset by additional expenditure on pay (£0.29m adverse to plan) and non-pay (£10.08m adverse to plan).

Pay is overspent by £0.29m due to additional staffing resources required to deliver services in response to COVID 19 this is offset by vacancies in Senior Positions. Non pay is overspent by £10.88m due to additional goods and services being transacted through the company the majority of which relates to COVID 19. Total income is above plan by £10.13m which reflects

the additional income invoiced for the goods transacted through CHS and Contract Variations relating to additional services.

Year End Forecast

The year-end forecast is £0.59m against a plan of £0.73m with a £0.14m adverse variance. The forecast is based on variations approved to date. Variations are now updated as at month 10 with approval from IMT and relevant general managers. Going forward work is now being undertaken in the form of restart groups which will look at different ways of working in order to address a third wave of COVID admissions and given a return to business-as-usual what cost pressures CHS will face in terms of delivering services. The adverse forecast of £0.14m is due to further slippage in CIP, an expectation that third party income will not be realised. (£50k), additional overtime payments due to staff sickness /shielding in the first and second wave of COVID. And pressures in transport services relating to the operating licence which resulted in additional vehicles being leased.

CIP

CIP is above plan by £0.02m in month; this relates to additional procurements schemes in maintenance and additional savings in staff recruitment through CHS terms and conditions. The year-end position is forecast to come in on plan despite slippage of schemes due to COVID 19 through non recurrent savings.

3.3. Workforce

3.3.1 Attendance

CHS Sickness rate for January is 4.84%, comprising LTS 3.08% and STS 1.76%.

This compares with the Trust overall rate for December of 4.40%

Chest and respiratory infection remain the main reason for absence at 25.30%

Covid isolation rates are continuing to improve. For clarity isolation types include: Self, Household, Test & Trace, Surgical and Post Travel Quarantine

CHS currently has 18 Clinically Extremely Vulnerable staff who are shielding.

The Government is due to review the position on 21 February 2021.

3.3.2 Appraisal and Essential Skills Training

Appraisal and EST KPI's are both excellent at 98%+ and 95% + respectively.

3.3.3 Recruitment

In planning for a potential third wave, we have sourced Agency cover for staff with enhanced training requirements (switchboard and portering) and staff are currently carrying out training in the relevant departments.

The Trust have asked for additional intensive touch point cleaning on 7 ward areas for 14 hours per day. This equates to 10 additional staff at short notice.

These staff are being sourced both via agency and our preferred option, the Flexible Workforce Team, focussing on HCA's who may be interested in additional hours, are familiar with the hospital and will be available at short notice.

3.3.4 Staff Survey

The Staff Survey 2020 closed on 27 November 2020.

Our overall response rate is 50% *(212 respondents from an eligible sample of 425 staff),* which is an improvement on last year's rate of 47%.

Although embargoed until NHS England reports are published late February/early March,

results generally show some good improvement with an increase in our overall engagement score from last year.

4.0 KPIs

We continue to deliver a large number of KPIs as ‘green’, 3 KPIs (from a total of 68) did not achieve Green in November, which were:

Porters - Immediate response time jobs.
Catering - % of patients that respond regarding meals as very good, good or acceptable.
Cleaning – % of number of bed cleans carried out per month, against numbers requested.

5.0 Risks

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

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

- HRI Estates failing to meet minimum condition due to age and condition of the building (20)
- Resus – Collective risk to maintain compliance / upgrade (20)
- ICU – Collective risk to maintain compliance / upgrade (20)
- Medical Engineering - There is a risk of equipment failure from Medical Devices on the current trust asset list (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 – February 2021

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	4	0
Red Risks High	2	0
Amber Risks Moderate	28	0
Green Risks Low	11	0
Total	45	0

Risk ref + score	Strategic Objective	Risk	Executive Lead	Sept 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 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)	=16	=16	=16	=16	=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

Proposed Timetable for Governor Elections 2021

Action	Date
Provide postal & e-mail data for issue of nomination forms to UKE	09/04/2021
Issue nomination forms (post and e-mail) to members	19/04/2021
Publication of Notice of Election	19/04/2021
Last Day for Publication of Notice of Election	27/04/2021
Deadline for receipt of nominations	14/05/2021
Publication of Statement of Nominations	17/05/2021
Uncontested report provided to CHFT	17/05/2021
Deadline for candidate withdrawals	19/05/2021
Provide updated postal and e-mail data for issue of ballot packs to UKE	28/05/2021
Notice of Poll/Issue of ballot packs	01/06/2021
Close of Poll 5.00pm	01/07/2021
Count and Declaration of Result	02/07/2021
Reporting of results at CoG meeting	15/07/2021
Formal election results announced at AGM	TBC

UKE – UK-Engage, CHFT's election provider for 2021