Public Board of Directors 4 November 2021 - Items for Board Assurance

Organiser Amber Fox

Documents for Review

1. Annual / Bi-Annual Reports

1. Huddersfield Pharmaceuticals Specials Annual Report

Annual Report FY2021
Huddersfield Pharmacy Specials

1. Introduction

Huddersfield Pharmacy Specials (HPS), also referred to as the Pharmacy Manufacturing Unit (PMU), is a division of Calderdale & Huddersfield NHS Foundation Trust. HPS is a manufacturer of unlicensed sterile and non-sterile products known as Specials. Additionally, HPS provides a medicines over-labelling and re-packing service to hospitals and private providers, both contract manufacturing and research and development, and wholesaling of licenced medicines. Of particular note (and as previously announced), during FY21 HPS continued the commercialisation of clinical trial services provided to third party organisations. We present below key achievements and the division's operational and financial performance during the financial year FY21 (1st April 2020 to 31st March 2021).

2. Structure, Governance and Management

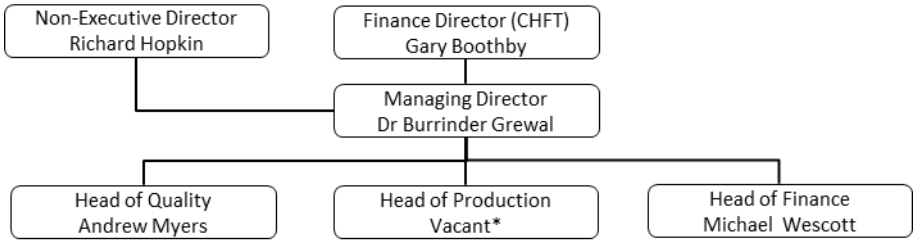
HPS trades from purpose built facilities (33,000 sq. ft. of space) located at Acre Mill (School Street West), Huddersfield. The unit operates under the authority and licences issued by The Medicines and Healthcare Products Regulatory Agency (MHRA), the UK medicines regulator. The licences the unit have which permit it to operate, manufacture and provide services are listed below; no additional licences were added to the list during FY21.

Table 1: HPS licences and certifications

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

On a day to day basis, HPS is run by a Senior Management team headed by a Managing Director who in turn reports into the Trust's Finance Director; the Senior Management Team meets at least once a week formally and at other times on a specific project by project basis. The board of HPS consists of the Senior Management Team, the Trust Finance Director (also the board chair) and a Trust Non-Executive Director. Board meetings are held every two months although management and financial reports are produced on a monthly basis and the Managing Director and Trust Finance Director meet monthly. The current board governance structure is given below and the names of those in post (as at 31st March 2021)*.

Figure 1: HPS Governance structure



*Post period, Mr Stuart Tolson was appointed as the new Head of Production who commenced employment in August 2021.

3. Workforce

The make-up of the HPS board was unchanged with the current Managing Director and Head of Quality having completed their 5th and 11th years in post respectively during FY21.

Staff in post at the commencement and end of FY21 numbered 69 and 66 respectively. On a whole time equivalent basis, HPS employed 61.12 WTE at the beginning of FY22 (a decrease of 3.59 WTE's during FY21).

Table2: HPS staff numbers

	End of					
	FY16	FY17	FY18	FY19	FY20	FY21
No. staff in post (SIP)	56	64	63	62	69	66
No. WTE	51.45	59.60	58.44	57.72	64.71	61.12
Annual staff turnover	4.16%	5.38%	6.27%	4.50%	8.78%	10.95%

Table3: HPS staff numbers by function (March 2021)

Function	SIP	WTE
Sterile production	14	12.92
Quality Control and Assurance	11	10.00
Sales, customer services and warehouse	10	9.20
Non-Sterile Production	7	6.20
Tablet packing	8	7.20
New product Development	5	4.60
Cleaning/domestics	4	4.00
Finance	3	3.00
Senior Management Team	2	2.00
Clinical Trials	1	1.00
Regulatory Affairs	0	0.00
Project Management	1	1.00
Total	**66**	**61.12**

SIP=staff in place, WTE = whole time equivalents

Appraisals and mandatory training: At the commencement of FY22, HPS reported 100% completion of staff appraisals covering FY21. Mandatory training completion rates ranged from 85.71% to 100% across the 9 training requirements.

Sickness: At the end of FY21, HPS had an annual sickness rate of 2.97% (long term 1.95%, short term 1.02%) versus a Trust target rate of approx. 4.00%; the estimated cost to HPS of this sickness was £50K.

Staff survey: During FY21 HPS received staff feedback arising from the Trust wide staff survey and accordingly, further consulted with colleagues; at the time of writing HPS is working to fully implement a program of change and recommendations which is being overseen by CHFT's HR Executive Director and the board of HPS.

4. Finance

During FY21 HPS delivered income of £15.4m and returned to the trust a contribution of £3.4m; as is shown below (table 4).

Table 4: HPS financial results FY21

	FY16	FY17	FY18	FY19	FY20	FY21
Income	£7.1m	£7.8m	£9.8m	£12.4m	£15.3m	£15.4
Contribution	£2.2m	£2.3m	£2.8m	£2.9m	£3.4m	£3.4m

The main contribution generating functions within HPS during FY21 were sterile and non-sterile production, tablet packing and wholesaling. Furthermore, from a cost perspective staff continue to contribute to the process of reviewing all business expenditure (for example, historic plant and equipment maintenance contracts which were identified as an area of review in-order to decrease operational cost).

Revenue wise, sales were split across our functions as set out below (table 5) during FY21.

Table 5: HPS revenue analysis FY21

Function	% of FY17	% of FY18	% of FY19	% of FY20	% of FY21
Tablet packing	29.8%	42.9%	29.9%	27.0%	18.22%
Sterile production	36.9%	25.4%	21.4%	14.7%	15.94%
Non sterile production	27.0%	20.2%	16.8%	14.2%	10.81%
Contract manufacturing*	-	6.3%	4.6%	2.6%	2.52%
Wholesaling	-	2.0%	24.2%	38.3%	46.42%
Contract research	3.0%	1.0%	0.1%	0.2%	0.46%
Clinical trials	-	0	0.9%	1.1%	3.01%
Others**	3.3%	2.2%	2.1%	1.9%	2.62%

* Included in sterile production figures in FY17

** Delivery charges and small order handling charges

Agency spend: There was no spend on agency at close of FY21 and there is no planned agency spend for FY22.

Capital Expenditure: During period HPS drew/was allocated a total £694K of capital spend (£109K in FY20) to purchase new autoclave controls (£470K), an oral liquid filling line (£204K) and £20K was spent on purchases related to introducing tablet manufacturing into HPS.

Aged debt: The aged debt position for the unit deteriorated by £520K from period opening and closing values of £1.89m and £2.41m respectively, mostly due to on-going trading experienced during the year. That said, the senior team monitor aged debt on a monthly basis and continue to pursue mitigation measures such as requesting card payment at the point of customer order and a formal process of debt "chasing" where customers have had accounts put on stop until monies owed have been paid.

Table 6: HPS aged debt position FY21

	FY17	FY18	FY19	FY20	FY21
Period opening value	£0.92m	£1.08m	£1.32m	£1.72m	£1.89m
Period closing value	£1.08m	£1.32m	£1.72m	£1.89m	£2.41m
Change in period	+£160K	+£240K	+£440K	+£170K	+£520K
Current debt (%)*	61%	52%	33%	26%	23%

*invoices issued that are less than 30 days old

5. Business activity and strategy

Historically, HPS has supplied product to every NHS Trust in the UK. During period, HPS traded with 254 NHS organisations and approximately 202 private companies (mainly corporate/independent pharmacies). Some 36% of revenue was derived from NHS organisations; revenue originating from private customers increased from 57% (FY20) to 64% in FY21. Based on our underlying strategy, we anticipate that over the coming years the share of revenue from the private sector will further increase due to HPS diversifying into contract

research and manufacturing (where the customer typically will be pharmaceutical companies), clinical trials, licensing of products, wholesaling of pharmaceutical products and exporting (of licenced medicines) etc.

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

HPS throughout FY21 pursued and delivered a business strategy that sought to enhance or develop sales in the following areas;

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

Overall, the strategy is proving to be successful with the unit now having identified and developed a strong pipeline of licensable products which are being progressed through regulatory licensing/approval procedures. Accordingly, HPS established an in-house medicines regulatory function during FY19 and FY20 with the recruitment of an industry experienced regulatory affairs manager that will provide internal expertise and expedite the process to apply for marketing authorisations (MA's, i.e. licences that allow HPS to manufacture specific medicines). As a result of the above, the period saw HPS for the first time in its history submit product applications to the UK regulator to license medicinal products (both in independently and in collaboration with partner organisations, numbering three in total).

Clinical Trials: The manufacturing of medicines to be used in clinical trials (investigative medicinal products (IMPs) and related services to deliver clinical trials was a business area that HPS did not actively participate in three years ago. However, in-line with our 6 year strategy this was identified as a business opportunity for HPS and accordingly through renewed focus and recruitment of delivery resource HPS has enjoyed significant success during FY21 wining further work to deliver clinical trial services to the NHS, academia and industry.

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

Engagement with clinicians: The unit continues to increase its visibility and interactions with clinical colleagues based at CHFT and the wider region, which has resulted in a number of new products currently being developed that will be launched in FY22/23. Such activity forms a sound basis for the future growth of HPS.

Accordingly, HPS will continue business activity in the above areas and commences FY22 with a strong sales pipeline.

6. Forward plan and strategy for FY22

Looking forward HPS has embarked upon FY22 with a similar strategy as that set out above for FY21 and we expect to report significant progress against each strategic aim during the course of the coming year. In particular during the course of FY22 HPS is seeking approval of the market authorisations submissions that are being reviewed by the UK medicines regulator. Equally important (and fundamental to ensuring the future performance of HPS) is obtaining financing that allows the delivery of identified strategic objectives.

2. Items for Review Room

- CHS Managing Directors Report - October 2021

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

OCTOBER 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

Construction works have commenced on the new Learning Centre at HRI, this is on the sub basement corridor. Works are anticipated to take approximately 12 weeks.

The demolition of the old Learning Centre and Nurses Residence is well underway, with the main demolition due to be completed by the end of November, and the landscaping works to be completed by February 22. The team are working closely with colleagues in IPC to mitigate risks to patients in ward block 2 from exposure to dust particles. All external windows facing the demolition site have been sealed shut and air purifiers installed in ward 12 due to the patient group. We are working closely with the main contractor looking at the existing concrete slabs to ascertain whether an amount can be retained to create additional parking due to capacity issues on site with the new ED build soon to commence on South Drive.

2.1.2 Community

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

2.1.3 LED Scheme

The LED scheme continues to progress at HRI albeit with challenges around timescales and delivery. The HRI programme is currently around 85-90% complete and is already saving both energy and money. The delays are access to areas due to operational activity. Such as bed head lights and ICU.

2.1.4 Fire Safety
Fire safety remains an area of focus at HRI. A recently completed fire audit by Mott MacDonalds has been reviewed and a capital plan of £400k has been approved. CHS are working alongside the Trust fire officer and the Fire Committee to prioritise the action plan following the audit and to commence design to roll out the capital plan.

The actions are around, community fire door remediation, HRI 30 min compartmentation, fire plans and signage. Architects have been appointed to create a package of fire compartmentation drawings for HRI and Community estate. A lift survey has also taken place looking at the suitability of existing lifts on the HRI site for fire evacuation purposes. The outcome of this survey is due this week.

2.1.5 Portland Stone
A paper has been drafted to Programme Transformation Board recommending the new cladding system is installed in Year 5 post completion of reconfiguration plans at CRH. This will allow us to decant a whole ward block to allow the cladding solution and required internal works to be completed in a vacant space which will create efficiencies and allow us to address further significant backlog maintenance and ageing infrastructure.

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

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

2.1.8 ED Development
The new ED scheme had planning approved in September 21. The team are working closely with the main contractor to value engineer the scheme within the £15m project envelope. Enabling works are due to commence from 15th October 21 with significant impact to areas on South Drive. We have been working closely with comms to roll out stakeholder engagement and ensure mitigations are put in place inline with aspergillus policy for clinical areas on ward Block 1. The enabling works which is predominantly the demolition of Saville Court and the diversion of services are due to complete early January and the build will commence. The current programme suggests a completion date of Jul 2023.

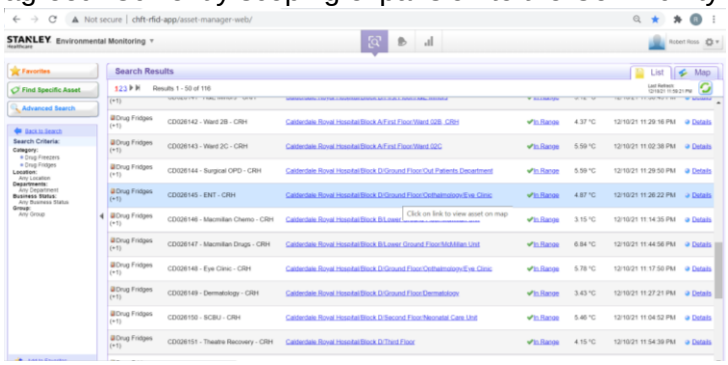
2.1.9 Learning & Development Centre CRH
Estates are working closely with the reconfiguration and procurement team to issue expressions of interest letters via the Crown Commercial Services (CCS) Framework for a

modular design & build to create a new facility on the Dryclough Close site to the side of CRH. The scheme is anticipated to cost in the region of £7m and a timescale of completion Q1 2023.

2.2. Medical Engineering & Decontamination Service

2.2.1 Active Temperature Monitoring

Planned roll out to 3 trial areas by the end of the month, dependant on staff training compliance. This has been communicated to CHFT along with the revised SOP which has now been agreed. Currently scoping expansion to the Community sites.



2.2.2 Surgical Instrument Set Review and Loan Process

The instrument loan process has been added to the next Contracts meeting agenda. The first Business case is due to be presented to CMG to purchase a Surgical set that has been rented previously, the purchase will avoid the rental costs and added decontamination cost pre use which is included within the rental period.

2.2.3 Patient Monitor replacement program

We have been working with GE and Surgical Division for some time now and are nearing the end of the planned replacement of the Theatre monitors which is forecast to be complete within the month. Below you can see the wall mounted monitors in recovery at CRH (2 pictures on the left) and the 2 different mounting options for anaesthetic machines (2 pictures on the right). We have also started work at HRI recovery and Theatres.

2.2.4 Development of Acute Respiratory Care Unit (ARCU)

We have been working with Medical Division to aid in the development of the proposed ARCU on Respiratory floor at CRH, we have managed to source extra ICU specification monitors in order to equip the 10 level 2 beds. Have suggested that the ARCU be planned into the specification of the new build at CRH, as the current Respiratory floor does not meet the needs of the service, with regards to O2 supply capacity and ventilation to remove excessive O2 build up.

2.2.5 Mitigation of excessive demand on O2 pipeline supply

With the rising number of respiratory patients requiring high flow O2 via NIV, there have been times when potential demand has exceeded supply capacity by a significant margin. We have managed to source some oxygen concentrators, which may offer a solution by enabling the lower flow O2 between 2 – 10 Lpm to be supplied to the patients without need to access the pipeline supply. We are in the process of beginning the training and planning the trials areas, this is not an ideal alternative, but gives an option to the Respiratory team to help their position.

2.2.6 Training Compliance

CHS training compliance for Medical Devices remains above 95% and setting the standard for the Trust to follow. We have seen a marked increase in compliance over the last 6 months from Corporate Division who have been working closely with the training team and have seen a 25% rise in compliance with just a 2 % fall in the last month, however there is now a general downward trend in Trust compliance. I do however understand the pressures placed on the frontline clinical staff and their need to prioritise their time, also the new medical devices that are being added to the list, which has impacted on compliance.

Division	August	September
Surgical	66%	65%
Medicine	60%	59%
FSS	82%	80%
Community	80%	82%
Corporate	73%	71%
CHS	95%	96%
Trust	76%	71%

2.2.7 Scoping space for Medical Engineering

We have put forward a request for funding, to renovate old Ward 10 as this area is not likely to ever be returned to clinical use, this would free up an area for return to clinical use and bed spaces, whilst giving the department the much-needed space to complete our work securely, safely and enabling the future expansion of the department to support the planned developments at CRH.

2.2.8 Decontamination and Repair of Mattresses

The decontamination and repair service is now working well we are still achieving in excess of 95% availability daily, this has been enabled by the now smooth process and the hire of additional mattresses to meet increased demand.

2.2.9 KPI compliance

CHS Risk 7438 & CHFT Risk 7474 Rating 20 relating to Medical Device Maintenance, although compliance has increased across all risk categories this month. We have been completing the audits with ward/department areas, and additionally we have been targeting Theatres as part of the audit days, however we are now at the point where we need to come up with a significant step change in order to mitigate this risk within target date, therefore, I proposed the following plan to Medical Device Procurement & Management Group, which was agreed this month and will be put into policy at next amendment and be included within SLA & reverse SLA:

That the route forward is to compile a compliance report for Divisions on a monthly basis, where we drill down to a ward/ department areas outstanding work, this will come as a percentage and compliance target.
Green will require.

- >95% High Risk assets.
- >90% Medium Risk.
- >85% Low Risk.

Amber will be.

- 90% to 95% High.
- 85% to 90% Medium.
- 80% to 85% Low.

Red will be.

- <90% High.
- <85% Medium.
- <80% Low.

Any assets listed as out of compliance to be presented/identified in month to Medical Engineering for maintenance, if not found by the Ward/Department in month these assets are to be written off by the Division, these assets will then be archived within eQuip, which will remove them from the compliance targets, but will enable them to be reactivated if found later, but only once outstanding maintenance has been completed.

2.2.10 Student Placements

We had recruited 3 placements that would be with us for the forthcoming year, but we have had 1 pulled out by the University due to financial reasons, the remaining 2 Renee Lujilibana & Safa Hussain, have now started and are settling in, we have been engaging with the University to seek a replacement for the position that has been vacated.

2.2.11 Observations into EPR (S4S)

We have completed the successful proof of concept with THIS & Mindray by attaching a barcode scanner to an observations monitor (VS900), admitting a patient ID to the system drawing the information direct from Nerve Centre and populating on screen, then taking a set of observations saving them on the device and then Nerve Centre pushing them to the Zebra in a second for review and authorisation and highlighting readings that would trigger NEWS2 scoring. Business case is being reviewed as we have managed to do this without engaging with Cerner to integrate the system and doing it purely via Nerve Centre, also the number of devices in use in the Trust has doubled from initial plan.

2.3. Facilities

2.3.1 Covid Support

Facilities services have further been able to step down some of the additional services, which we have been providing over the past 18 months. There are only a couple of areas within cleaning services which are being approved on a month-by-month basis.

2.3.2 Laundry Tender

The laundry tender process is now in its final stages with the “intention to award” letter at the checking off point. The intention is to commence with the successful provider as from 1 November 2021, providing there are no challenges from the unsuccessful provider

2.3.3 Retail catering

The new retail outlets are due to open early November and final preparations are being undertaken. Weekly comms are being circulated as are samples of menus. Flyers and posters, advertising the new areas are being distributed to all wards and departments. New posts are out to advert and uniforms have been agreed and are on order.

2.3.4 Enhanced shuttle service

Plans are on place to introduce a park and ride service in the autumn, which will run from Broad Street Plaza to CRH. This will enable staff to park off site whilst works are being undertaken to complete the multi storey carpark at CRH

2.3.5 Staffing

Staffing is incredibly challenging at present due to long term sickness, inability to recruit, and covid related conditions such as self-isolation or returned shielders, who are unable to carry out full duties. The cleaning services has been hit with significant sickness as well as having several vacancies which are proving difficult to fill. We are currently exploring other options to help with recruitment and at present are liaising with Job centres in Calderdale and Kirklees to look at raising our profile and encouraging staff to work for CHS

2.3.6 National Cleaning Standards

New NHS Cleaning Standards have been launched with a 12-month implementation period. Work is progressing and is on target for completion and implementation by the given date and we are just awaiting CHFT to complete cleaning charters when we will look at cleaning schedules and frequencies

2.3.7 BICS (British Institute of Cleaning Science)

Training of 46 Domestic staff has taken place so far with a plan to have all domestics trained by Spring 2022. We saw 3 new assessors verified in September and the company received reaccreditation to continue as a BICS training centre, which was a good achievement

2.4. Procurement

2.4.1 Materials Management

September has been incredibly challenging for all teams again due to planned annual leave, long term sickness within the HRI matman team, a Covid positive case & medical issues affecting two members of staff that are on light duties only. Daily PPE provision is increasing in volume in line with clinical demand along with lateral flow test requests for distribution.

The Covid Vaccine centres in each hospital are up and running now with a weekly provision of non-vaccine clinical consumables. All PDRs have been completed and are logged on ESR. Current issue within the HRI team now is lack of space due to Estates working on the old Clinical Coding Room.

NHSSC / WYATT:

- Clean ‘sweep’ days arranged for NHSSC to come on site and retrieve as many cages as possible to help with Xmas deliveries. All CHS service managers, Pharmacy & Pathology have been informed.
- Pipeline projects this month are still sterile instruments but endoscopy consumables has progressed with a £10k saving. CIP work has had to go on hold due to operational activity and resource issues.
- WYAAT savings agreements still require sign off from WYAAT trusts who are also experiencing resource pressures – this affects needle free devices, gravity admin sets and iodophor dressings.
- WYAAT spend comparison tool was shared this month to work through with potential savings opportunities.

Scan4Safety:

- Interviews set for the 20th October for the B5 Specialist Inventory Supply Chain Manager & the B4 Materials Management Inventory Supervisor. Four staff have applied in total.
- Four staff identified as System Administrators and will attend a two day training session in Manchester in November. These will be the super users of the IMS.
- Tentative go live date is the 16th December in ESU, HRI.

2.4.2 Category Management

The team are currently processing a high volume of BAU activity and COVID recovery for contracts and procurements that were extended or rolled forward. The Procurement Team have made fantastic progression with the CIP savings.

Procurement services to date have delivered £154k of savings to 30 September 2021. The FYE of these savings plus additional schemes due to commence in the second half of the financial year total £328k.

Further to this Procurement have identified a number of schemes around clinical maintenance, pacemakers and supply chain initiatives totalling £207k PYE £424k FYE.

Furthermore, in addition to the realised savings the Procurement team have delivered £570k in cost avoidance.

The e-commercial and Contracts Officer interviews take place Thursday 14th October, and we hope to have the person in post as soon as possible. The role will implement the Atamis e-commercial solution which will be rolled out across the Trust for all procurement and contract awards in the drive towards making both CHFT and CHS compliant with Public Contract Regulations and evidence value for money.

2.4.3 Operational Procurement

The team continue working as part of the catering project, this is all on track for the go live date and the team continue to support the project team as necessary. We are working on a prescription eyewear project with stakeholders from the Trust to put in place a contract which will enable staff to receive prescription eyewear to allow them to conduct their duties safely and with the correct PPE. The contract for this is about to be signed with expected start date in November. We are currently working with Ophthalmology for bespoke face shields, a prototype is being ordered this week for review by the dept and IPC. The team have been supporting on the reconfiguration project and will be involved in the procurement workstream to deliver the procurement activity for the Reconfiguration programme. The team have worked to provide indicative pricing for the ED aspect and will continue to support as necessary. We have worked to implement consolidated POs/invoices with one of our rental suppliers, 1st call mobility, to create one PO for the organisation for the year and monthly consolidated invoices. This will significantly reduce invoice queries for this supplier as well as time taken by procurement and AP to process POs and invoices. This will go live November 1st at the start of the new contract. The team are working to identify savings to contribute to the CIP programme. We are participating in housekeeping exercises to reduce accruals prior to financial month end close down and are working on actioning invoice queries in collaboration with Accounts Payable. The Scan4Safety project continues to progress, we have submitted catalogue data for wave 1 suppliers and this is in review by LTH in preparation for the roll out of the Inventory Management Solution. LTH have confirmed they are 98% of the way through the data and will be completed by the 14th October. Testing is underway and will continue over

the next weeks in preparation for roll out. ESU is currently the planned first area for deployment and discussions are ongoing to identify go live date.

3.0 CHS

3.1. Spotlight Awards

August / September

During September Sandeep supported both the ward and catering department and has shown dedication, empathy and understanding of the behaviours expected of employees.
Whilst collating menus on a ward Sandeep noticed a gentleman who was agitated and upset. Not ignoring this Sandeep then went to speak with the gentlemen to ensure he was OK and to ask for his meal choice, but he only spoke Punjabi and he had had issues communicating. He had not been eating much so Sandeep, who speaks Punjabi, sat with him and went through the menus and encouraged him to pick something to eat, offering to cook him something if nothing took his fancy. She relayed this information back to the catering team, the patient then began eating regular meals. Subsequently, Sandeep worked with the collating team / catering and helped with interpretation to ensure that we were able to help with his meal choices, ensuring he was looked after whilst here.

Sandeep epitomised the behaviours expected of all employees and followed the four pillars, especially “putting the patient first”. Sandeep did mention he did remind her of her Grandfather.

3.2. Finance

Month 6 - September 2021

The month 6 position reports a £0.04m surplus against a plan of £0.07m with a £0.03m adverse variance. This position results from the over recovery of income (£2.11m) due to an increase in the goods and services being transacted through the company offset by an overspend on non- pay (£2.14m) (adverse to plan). Pay is in line with budget. Non pay is overspent by £2.14m due to an increase in goods and services being transacted through the company. Total income is above plan by £2.11m which reflects the increase in income invoiced for goods and services requested by CHFT.

Year To Date

The month 6 YTD position reports a £0.43m surplus against a plan of £0.46m with a £0.03m favourable variance. This position results from the over recovery of income £9.81m (favourable to plan) due to an increase in the goods and services being transacted through the company offset by an overspend on non- pay £9.75m (adverse to plan). Pay is £0.01m overspent (adverse to plan) due to additional staffing resources required to deliver services in response to COVID 19, this is offset by vacancies in Senior Positions and through funded variations agreed with CHFT. Non pay is overspent by £7.62m due to an increase in goods and services being transacted through the company. Total income is above plan by £9.81m which reflects the increase in income invoiced for goods and services requested by CHFT.

Forecast 2021/22

The year-end forecast shows a £0.08m adverse variance to plan and is a result of undelivered CIP.

Capital 2021/22

The month 6 position reports a £305k underspend to plan in main due to the deferment of the Learning centre development to Autumn of this year (£375k). The year -end position forecast to be within plan.

CIP 2021/22 Estates and Facilities

The target for CHS is £650k. At this stage schemes of £243k have been identified as recurrent relating to energy and waste and staff efficiencies. The forecast position shows £566k with a shortfall to plan of £84k.

CIP 2021/22 Procurement

The target for CHS is £850k. At this stage schemes of £154k have been identified as recurrent relating to NHS supply chain and maintenance contracts. The forecast position shows £425k with a shortfall to plan of £425k.

3.3. Workforce

3.3.1 Attendance

CHS Sickness rate for September is 7.03% which is a further increase on the August rate of 6.7%. This comprises of LTS 5.27% and STS 1.76%. Covid sickness and isolations continue to impact on staffing levels.

Whilst short term sickness has remained relatively stable throughout the year and has decreased slightly this month, long term sickness (over 28 days) remains a significant issue and has risen sharply over the last 4 months.

A deep dive into each case has taken place and a separate paper has been provided to Board of Directors this month in this regard. Stress and anxiety accounts for 32% of current absence with musculo-skeletal issues remaining high at 25% followed by chest/respiratory infections at 12%.

3.3.2 Appraisal and Essential Skills Training

Mandatory training is green at 90% + in all areas. Appraisals stand at 45% currently with the season due to end at the end of October. Due to staffing and workload issues within CHS there may be an option to extend the season until end of November. The practicality of this will be discussed with the senior team.

3.3.3 Staff Survey

The 2021 staff survey launched on 27 September 2021. CHS response rate at 12 October is 23.3% *(103 respondents from an eligible sample of 443 staff)*.

Reminders are being sent to colleagues in a structured way via, team briefs, notice boards, screensavers and email. The survey closes on 26 November 2021.

3.3.4 Retail Services – TUPE Transfer of Staff

Compass staff will formally transfer to CHS on 1 November 2021.

The HR aspects of the transfer are complete and arrangements are underway for a welcome/induction meeting.

Modelling has taken place with regard to existing and future staffing requirements in line with funding arrangements. Shortlisting has taken place for an admin vacancy and Barrista positions (x3) are now out to advert.

We are offering a zero-hours contracted person permanent part time hours as part of this process and a vacancy in the retail shop has been offered as a redeployment opportunity to a current member of CHS staff with specific health needs.

4.0 KPIs

CHS provide 60 KPIs to CHFT of which just 3 **did not** achieve Green Target.

- **Medical Engineering –** High Risk PPMS – **AMBER – 78.54%**
- **Medical Engineering -** Medium Risk PPMS – **AMBER – 61.16%**
- **Medical Engineering -** Low Risk PPMS – **AMBER – 58.49%**

5.0 Risks

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

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

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

- Fire safety due to breaches in compartmentation, and a lack of compartmentation in some areas, and enough staff trained in fire safety awareness and as fire wardens (in CHFT) (15)
- The façade of HRI (15).

6.0 Recommendation

Shareholders are asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – September 2021

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

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

The Risk Register has been noted by CHS Board

3. Board Sub-Committee Minutes in the Review Room

- Finance and Performance Committee – 31.08.21
- Quality Committee – 16.08.21 & 13.09.21
- Audit and Risk Committee – 12.10.21
- Workforce Committee – 30.09.21
- Charitable Funds Committee - 23.08.21
- Organ Donation Committee - 13.01.21 and 07.07.21

Calderdale and Huddersfield NHS Foundation Trust

APP A

DRAFT Minutes of the Finance & Performance Committee held on Tuesday 31 August 2021, 11.00am – 13.00pm Via Microsoft Teams

PRESENT

Helen Barker	Chief Operating Officer
Peter Wilkinson	Non-Executive Director
Owen Wiliams	Chief Executive
Richard Hopkin	Non-Executive Director (CHAIR)
Kirsty Archer	Acting Director of Finance

IN ATTENDANCE

Andrea McCourt	Company Secretary
Jim Rea	Managing Director – Digital Health
Peter Keogh	Assistant Director of Performance
Rhianna Lomas	PA to Director of Finance (Minutes)
Suzanne Dunkley	Director of Workforce & Organisational Development (Item 137/21)
Stephen Baines	Governor Representative

ITEM

128/21 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

129/21 APOLOGIES FOR ABSENCE

Apologies were received from Gary Boothby, Stuart Baron and Anna Basford.

130/21 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

131/21 MINUTES OF THE MEETING HELD 02 AUGUST 2021

The Minutes of the meeting held 02 August were **APPROVED** as an accurate record.

131/21 ACTION LOG AND MATTERS ARISING

The Action Log was reviewed as follows:

125/20: Outcome Based Indicators – It was noted that the information has not yet been finalised therefore a future date will be planned. This work will be taken on by the Chief Operating Officers successor alongside the Assistant Director of Performance. **Action remains open.**

069/21:H2 Financial Plan – The ICS is running an information gathering exercise regarding exit run rates and pressures. The Acting Director of Finance will share this information once available. However, there is still no confirmed guidance for H2. **Action remains open.**

122/21: Efficiency Engagement Project – An update regarding this is planned for next month. The Acting Director of Finance and the Director of

Transformation and Partnerships will work towards this date. **Action remains open.**

116/21: High Level Risks – Covered within item 132/21. **Action closed.**

117/21: Neck of Femur Performance – Deterioration has been ongoing, and mortality is worse than the national average. The 3 Rs process identified that CHFT aim to be above 70% on patients going to theatres within 36 hours and to be better than the national average on mortality. Covid has made progress harder however the service struggled prior to this and therefore the pandemic is not the main driving factor. It was noted that neck of femur should be first on the list followed by the specialty however this is not being seen. It has been identified that some clinicians have been focused on elective work and not the trauma lists therefore these have been covered by the registrar which presents an opportunity for improvement. Investigations also highlighted some data quality issues between the weekly performance report and the IPR.

Process mapping of the pathway will be done. The lead anaesthetist and surgeon are looking to gain clear consultant leadership and a deep dive will be done regarding the mortality rate. The National Hip Fracture Data Base has a national improvement initiative that CHFT are submitting a business case for. Work is also being done to create a business case for a Trauma Consultant. In the long term, CHFT wish to re-establish the conversation with elderly care regarding them being responsible for fractured neck of femur and an Orthopaedic Surgeon assisting. It was noted that Trusts that have implemented this way of working have good mortality rates. The Director of Operations is attending theatres regularly and working with clinical colleagues on list composition and efficiency (the trauma list is part of this process.) An audit of the improvements will be done in Q4 and an update will be provided to the Committee in February 2022. The Chief Operating Officer proposed that the clinical team provide this update rather than her successor.

The Chief Executive expressed that February is too late when higher mortality is concerned. It was suggested that a go see to NHS Trusts with good performance and low mortality rates be done. It was agreed that the clinical team/Clinical Director will update the Committee in November as well February.

ACTION: For the Clinical Director and team to provide an update on neck of femur performance in November 2021 and February 2022 **– HB, 01/11/21**

Non-Executive Director, Peter Wilkinson, questioned why as documented in the report “a fractured hip is the commonest cause of injury related death in the UK.” It was noted that it is mainly caused by frailty as when some frail patients who live alone fall, they can be on the floor for several hours. This is particularly a post covid risk as frailty has increased and may impact the future position.

The Chair agreed that the data is concerning and questioned whether the GIRFT process had covered this area It was understood that the service was one of the first assessed however a follow up was not completed. It was also elective focused when done. The Committee noted that the outcome based IPR

is proving useful for flagging these issues and it was agreed that neck of femur performance should be discussed at Quality Committee also.

118/21: Recovery Trajectory – Covered within item 135/21. **Action remains open.**

FINANCE & PERFORMANCE

132/21 MONTH 4, FINANCE REPORT (INCLUDING HIGH LEVEL RISKS & EFFICIENCY PERFORMANCE)

The Acting Director of Finance highlighted the key points reported at Month 4:

- CHFT continue to report a year to date surplus. This has been driven by Q1 as the Trust received ERF. The thresholds were lower and easier to achieve at that time. In Q2, the surplus has decreased due to recovery costs and non-elective pressures/staffing issues, as well as no ERF.
- The forecast for H1 is a breakeven position. Breakeven at M6 is realistic.
- During M4 the threshold for ERF was increased from 85% of the 2019/20 elective activity to 95%. CHFT are therefore no longer forecasting receiving any ERF in M4, M5 or M6. This is an ICS wide trend.
- The agency position has gone from amber to green however this is because the threshold has been set by NHS improvement meaning CHFT is no longer measuring against the internal agency plan. Therefore, spend has not actually gone down.
- Pay enhancement has been agreed for bank colleagues in order to help with staffing pressures. This will impact in August and is anticipated to cost approximately £0.5m. It is contained within the breakeven forecast and based on four weeks. It has been extended beyond this time for a further review therefore causing a further pressure.
- The capital forecast shows a reduced spend of £14.6m against a plan of £18.99m. This reduction is based on a change in the profiling of the reconfiguration capital draw down and a reduction in critical infrastructure funding linked to timings on the cladding and the learning centre. There has been a £2.5m net reduction due to this. The change does not impact cash as the schemes were based on external funding. CHFT's forecast underspend will enable Bradford to have a forecast over spend. This has been agreed with a caveat for CHFT to draw on the resource next year.

It was questioned how other West Yorkshire Trusts are fairing as a result of the NHSE agency adjustment. The Acting Director of Finance agreed to investigate this. It was clarified that no capital plans have been stopped instead the underspend relates to timing changes. The Chair questioned the extension implications of the enhancement of pay rates. It was noted that the Executive Board have agreed to discuss it again next week. The increase has not had the desired impact at scale however withdrawing it without fair warning would have an adverse effect. Therefore, it will most likely be extended in order to give notice of its withdrawal. It may create a c. £0.5m added pressure depending upon the length of the extension.

High level risks: The risks have been reviewed; the narrative has been updated however no scores have been adjusted. The H1 financial plan is scored at 8 and the bank payments been included within the narrative. The H2 financial plan is scored at 20 and capital at 6. Cash is scored at 4 as CHFT are receiving block payments and continues to have substantial cash balances.

The Committee **RECEIVED** and **NOTED** the Month 4 finance report.

133/21 TREASURY MANAGEMENT

The Acting Director of Finance highlighted that the Trust has a high cash balance but nevertheless there is a continued focus on managing cash. The Cash Committee have set a trajectory for aged debt reduction to measure against internally. A large invoice was settled in July and some debt was written off at the Audit & Risk Committee therefore the trajectory progress is on track. From an Accounts Payable point of view CHFT are achieving the Better Payment Practice Code which is based on paying suppliers within 30 days. As discussed, the updated capital forecast does not impact cash. The Chair noted the requirement to monitor the aged debt position of HPS.

The Committee **RECEIVED** and **NOTED** the treasury management report.

134/21 INTEGRATED PERFORMANCE REVIEW – JULY 2021

The Chief Operating Officer reported that the Trust's performance for July 2021 was 73.4%. The following key points were highlighted:

- The overall percentage has increased this month. Four domains are in green and four are improving. Workforce is deteriorating and this will be covered within item 137/21. The responsive domain is slightly improving.
- Complaints performance remains good however this is in arrears and will likely dip next month. There have been staffing changes within the Quality Directorate. The team have temporarily stepped away from improvement collaborative work to focus on sending responses on time.
- Emergency care remains a challenge. Attendance levels have returned to normal winter attendance numbers however there are no summer and winter staffing models in ED therefore the department should cope. Twilight and overnight shifts are an issue. It was noted that the Liverpool system was served with an enforcement notice from the CQC due to overcrowding in ED, a pattern CHFT does not want to follow. The local community has a high Covid prevalence which provides another reason to avoid crowding.
- Bed occupancy remains high at 96-98% every day. Staffing issues are making it hard to open up more beds. The conversion rate of in patient admissions is down however length of stay is up and the average Healthcare Resource Group (HRG) cost has increased. Transfer of care numbers are high, there were over 80 last week while the plan assumes only 30. Social care also have staffing challenges. Care homes have vacancies and outbreaks, and the homecare position has been impacted therefore the rise is understandable There are gold meetings three times a week involving the local authority and CCG partners.
- There has been an increase in stroke admissions. A business case is being created and the team are looking at increasing beds. The service

has been knocked by staffing challenges and the clinical staffing model will be assessed. The stroke team will meet with the Committee in October.
- Cancer performance is positive. Referral volumes are high and face to face appointment issues are aiding this. CHFT will measure itself nationally to check whether the numbers align. Regarding day 28 faster diagnosis the Trust has a set of actions agreed to become positive again. The screening teams are being met with as they have struggled for the last three years. A tracking colleague has been employed as this proved a good idea nationally. They started this month, therefore an improvement should be seen soon.
- Planned care will be covered within item 135/21.

The Chair questioned the current Covid position to which it was noted that the overall inpatient number had risen to 74 and three patients had sadly died that morning. Bradford Teaching Hospital believe their numbers have peaked however CHFT feel that numbers are still rising. Non-Executive Director, Peter Wilkinson queried whether those dying had been vaccinated. It was understood that it has been a mixture; 2/3 in critical care had not been and one patient had received one vaccine. It was noted that younger age groups are presenting currently. The Chief Executive highlighted that CHFT must be alert not to focus too much on Covid as other services are now running again and there are staffing pressures.

The A&E attendances show that CHFT has the highest type one attendances to bed ratio. The Chief Operating Officer noted that the Trust is in a locality where there are no other provisions. CHFT also has a continued focus and drive on length of stay and being efficient with the bed base and this creates a challenge. It was noted that the Trust works the bed base well and remains flexible however even if more wards were to open there would not be enough staff to manage them safely. The Chief Operating Officer therefore asked the Committee to acknowledge the amazing work colleagues do despite the capacity challenge.

The Chief Executive expressed a concern that the IPR is perhaps being looked at too superficially as issues noted within the report like deep tissue, bed sores, dementia screening and still births to name a few have not been discussed despite poor performance data being shown. The Chair noted this view and the Company Secretary agreed that CHFT need assurance that the Committees are looking at the key data. This will be discussed further in the fortnightly meeting with Non-Executives. It was noted that assurance could be incorporated into the highlight reports. The Chief Operating Officer echoed this view and noted that Weekly Executive Board members have been asked how the IPR narrative triangulation can be improved. The Non Executives and Committee chairs will address this issue however Executive colleagues must also understand their responsibilities in this respect.

ACTION: To raise the concern at the upcoming Non-Executive meeting that the IPR is not appropriately discussed in order to gain assurance **– RH, 04/10/21**

The Committee **NOTED** and **RECEIVED** the IPR.

135/21 **RECOVERY UPDATE**

The Chief Operating Officer informed the Committee that good progress is being made with average wait times of the P2 and P3 patients, although total numbers are adrift of the trajectory. More patients are being added to the list and through August there have been capacity issues due to annual leave. CHFT remain confident that the P2 target for waiting times will be met by the end of September. A high volume of patients relate to trauma and orthopaedics. Patients will not be added to the list until they receive CCG authorisation. Work is being done to increase independent sector capacity and insourcing. The wellbeing hour will continue in a way that will not affect services. P4 progress is static, there are three cohorts of patients. Some have been offered dates and have chosen to defer, CHFT are working with WYAAT to return those patients back to the GP to be re-referred when they choose to accept. There is a complex cohort and an independent sector cohort. The new clinical director for trauma and orthopaedics is reallocating people into outpatients to free up theatre capacity. Some patient led validation is taking place by writing out to see if patients wish to proceed. Endoscopy insourcing is going well. Risks relating to recovery are staffing availability, deciding how to deal with additionality and finances. Nuffield's have said they can take some cases and they will be contracted with the CCGs.

The Chair questioned whether the trajectories had been reassessed as requested in action 118/21 - "To provide an update on the recovery trajectory at the next Committee meeting." It was understood that this has not yet been done as formal governance is required in order to re-set them. The Chief Operating Officer agreed to investigate this. Non-Executive Director, Peter Wilkinson, questioned how many patients are on the overall waiting list. It was understood that there are 35,000 patients on that list, and they continue to be added. The Chief Operating Officer agreed to create and circulate a slide showing waiting lists at a glance.

ACTION: To create and circulate a slide showing waiting lists at a glance **– HB, 04/10/21**

It was agreed to make the recovery update a monthly item on the workplan.

The Committee **RECEIVED** and **NOTED** the recovery update.

136/21 **BOARD ASSURANCE FRAMEWORK (BAF)**

The Company Secretary updated the Committee regarding the six BAF risks that the Committee have oversight on. It was noted that the Director of Finance and the Chief Operating Officer have updated them. The two performance risk scores have remained at 16. It was noted that the scores may need amending if services are stopped due to Covid. The NHSI compliance risk and the finance and commercial growth risk have all maintained their scores. Updates to the BAF are shown in red.

The Chair questioned whether the commercial strategy risk score of 6 is appropriate when the HPS financial position is challenging. The Acting Director of Finance agreed to review the score after the financial recovery plan has been reviewed at HPS Board. The Managing Director of Digital Health noted that THIS have a surplus currently and are forecasting to breakeven. There are also some upcoming opportunities. The Chair reminded the Committee that Andy Nelson, Chair of the Audit & Risk Committee requires the gaps in controls within the BAF to be completed. The Company Secretary reminded all to keep their risks updated.

The Committee **RECEIVED** and **APPROVED** the board assurance framework.

137/21 **AVAILABILITY DEEP DIVE**

The Director of Workforce & Organisational Development informed the Committee that staff wellbeing and patient care are hard to balance. It was noted that other regional and national Trusts are also struggling with staff availability and this is driven by staff isolation. 20% of the workforce is unavailable due to sickness absence, isolation, annual leave, study leave and other reasons. Non-Covid absence is up (by c 1.5% year on year) however not by enough to be the main cause; instead 25% of the unavailability is due to self-isolation. Annual leave has not been planned as well as usual and this has had an adverse effect however it is important that staff take it. 83% of the absence relates to clinical areas. Departments where they rely on flow have more than 20% unavailability which is not ideal. Rosters are being reviewed and training/guidance is being provided. Wellbeing initiatives will continue and Halsa are helping with this. Colleagues are struggling to self-identify what help they need. Wraparound care is being provided to the top 50 absentees and manager guides regarding 1:1s and supervisory support are being created. Work is also being done to investigate postponing mandatory and non-mandatory managerial tasks to free up time.

The Chief Executive highlighted that staff not knowing the answer is okay. It was agreed to continue to underpin what is on offer to ensure there is a bed rock of understanding. The WOD team must also manage their expectations of the impact these initiatives will have. Research into what other Trusts are doing will be done. The value of asking colleagues what they need and saying thank you to them was noted.

The Director of Workforce noted that colleagues are also fearful of what winter may hold and the cohort of staff that were redeployed in wave one are scared of being redeployed again. There are a cohort of volunteers being explored at St James Ambulance who could help as they are clinically trained.

The Committee **RECEIVED** and **NOTED** the availability deep dive update.

138/21 **DRAFT MINUTES FROM SUB-COMMITTEES**

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

- Urgent & Emergency Care Board held 13 July 2021
- Cash Committee held 27 July 2021

- THIS Executive Board held 28 July 2021
- Commercial Investment & Strategy Committee held 29 July 2021

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

139/21 **WORKPLAN - 2021/22**
The Work Plan was **NOTED** and **APPROVED** by the Committee.

140/21 **MATTERS TO CASCADE TO BOARD**
This will be covered within the Chairs highlight report to the Board.

141/21 **REVIEW OF MEETING**
This item was not discussed by the Committee.

142/21 **ANY OTHER BUSINESS**
It was noted that this was the PA to the Director of Finance' last Committee meeting before moving to a new role outside of the Trust. She was thanked for her service to the Committee. This Committee meeting was also the last one that the Chief Operating Officer would attend before departing her role. She was thanked for her long term service to the Committee and the significant contribution that she had provided.

DATE AND TIME OF NEXT MEETING:
Monday 4th October, 11:00 – 13:00, Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 16 August 2021

STANDING ITEMS

142/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
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
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Anna Basford **(AB)**	Director of Transformation and Partnerships **(item 147/21)**
Alison Edwards **(AE)**	Safeguarding Lead **(item 148/21)**
Dr Pratap Rana **(PR)**	Stroke Consultant **(item 146/21)**
Hannah Wood **(HW)**	Professional Lead for Transfer of Care and SAFER Transformation Programme **(item 146/21)**

143/21 APOLOGIES

Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs

144/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

145/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 19 July 2021 were approved as a correct record.

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

146/21 MATTERS ARISING

Stroke

Dr Pratap Rana was in attendance to provide a verbal update on progress in stroke services, following last month's Quality Committee meeting, where some questions were raised regarding the information within the integrated performance report (IPR) relating to stroke.

PR reported that four measures have been identified within stroke medicine, and targets are being met within the 10 domains. One that is failing is direct admission to the acute stroke unit and the 90% stay on the acute stroke unit after a patient suffers from a stroke. These two areas are limited to the availability of the beds. In February 2020, before the pandemic, a target of about 61% was being achieved for stroke patients being directly admitted to the stroke unit. During the pandemic, a stop was placed on rehabilitation and focus was on stabilising the patient and getting them into the community, hence the number of beds were reduced. Before the pandemic, there were 38 rehabilitation beds, however, the number of

beds were reduced to 20. During the pandemic, there was a proposal to establish stroke rehabilitation beds in the community, which continued for six to eight months, however, after exploring all the options in the community, it was concluded that it was impossible to establish a parallel or equally robust stroke rehabilitation unit in the Community and this was put on hold. The main factor about reducing the number of beds in the stroke rehab service, is the availability of the nursing staff. The reduction of the number of beds is thought to be safe option.

Following discussion, it was agreed that this needs further discussion outside of the meeting. to include the Community provision. CP stated that this is part of the stroke workstream in the Care of the Acutely Ill Patient (CAIP) programme but is not clear on what the quality measures are for the impact of this reduction in beds, particularly in light of what is taking place with out of hospital SHMI and whether or not there is a direct quality impact on our patients. Clare Vickers (Head of Nursing - Corporate) has been asked to liaise with PR about this.

The stroke team were thanked regarding the SSNAP data as this has once again improved.

SAFER Programme

Hannah Wood provided an update on the SAFER programme (see slides at the end of these minutes), which was launched earlier this year with a focus on quality improvement, service improvement and patient care. The meaning of SAFER was amended (**S**ee me; **A**dmission avoidance; **F**low from hospital to home; **E**arly intervention, and **R**eason to reside), in order to focus on priorities in terms of the work streams.

HW stated that SAFER is a supporting function and very keen for colleagues to own the pathways, and to make sure that where there is good improvement or good quality in one area, that this is shared with other areas to discourage work being done in isolation.

LR commented on the importance of patient stories being incorporated into the programme, and CP also mentioned that work from a current respect and care planning programme will need to link into the SAFER programme. The Chair welcomed a further update on the SAFER programme later in the year.

HW was thanked for the report.

OUTCOME: The Quality Committee noted the update.

AD HOC REPORTS

147/21 BUSINESS BETTER THAN USUAL

Anna Basford was in attendance to present appendix C, updating on progress against business better than usual, at the period ending for June 2021.

The report, which is submitted to the Transformation Programme Board, the Workforce Development Board, the Finance and Performance Committee and this Quality Committee, provides a self-assessment against each of the 12 themes that make up business better than usual. These were the key areas of learning which colleagues internally, and amongst our partners, identified the pandemic as areas to take forward to embed as a way of working both in how we respond now, but also to inform longer-term strategies.

Each of the 12 themes have been self-assessed, with five of the themes RAG rated amber, seven RAG rated green, with narrative against each of the themes.

Discussions at the Transformation Programme Board this month included agreement about how to improve this report in subsequent quarters, and in particular to provide more explicit statements around the rationale behind the RAG rating. On occasion, it was difficult to understand why something was rated amber as opposed to green or vice versa, therefore,

this will be made more explicit for the next report which will be produced for the period ending September 2021.

Colleagues continue to maintain the new ways of working, and some are becoming very much about the way we now work and going forward. It has become increasingly apparent that some of these new ways of working are becoming embedded for future strategic thinking about how we use our estate, how learning has been incorporated into design features for the new hospital builds, how it is informing our Technology Strategy, and also about the ongoing support to colleagues in terms of wellbeing, and the whole use of technology enabling working at home.

DS asked which of the individual work streams has been the most challenging. AB reported that the work on new ways of working in theatres with very significant challenges around elective care backlogs, and around availability of both workforce and theatre capacity, while still maintaining social distancing in the hospital, was very challenging. More recently, there has been focus on that stream of work about how we articulate our future ambition for how we will want to work on the Huddersfield site. We have the advantage of a dedicated planned site in 2025, and how to engage colleagues now to optimise new pathways and new ways of working in the way we deliver elective services.

OUTCOME: The Quality Committee noted the report.

SAFE

148/21 SAFEGUARDING ANNUAL REPORT

Alison Edwards was in attendance to present appendix D highlighting:

- *Prevent training*: All colleagues receive prevent wrap training and compliance has remained consistently above 90% throughout the year. Quarterly activity is submitted to NHS England and the Clinical Commissioning Groups (CCGs)
- *Safeguarding and COVID*: The Coronavirus Act did not suspend the duty to safeguard adults and children, and a contingency plan was developed to support the expected surge in safeguarding cases with the lifting of lockdown. Safeguarding continued as business as usual and operational services maintained.
- *Mental Capacity Act (MCA) and Deprivation of liberty safeguards (DoLS):* The safeguarding team continue to quality assure all DoLS applications and continue to provide evidence that DoLS are the least restrictive option, and in the patient's best interest. Referrals for the past year have continued to increase.
- *Training*: A selection of e-learning packages were developed where colleagues are required to self-certify to confirm compliance. This will shape safeguarding training going forward. The Trust position at the end of March 2021 for compliance was 92.84%. Receipt and scrutiny training has continued, and the trust position at the end of March 2021 was 65.1%. Safeguarding children supervision has been delivered virtually and compliance has increased by 5% since April 2020. Safeguarding supervision is being introduced into areas where colleagues work with adults at risk.
- *Adult safeguarding*: monthly analysis has identified an increase in safeguarding referrals, largely in relation to poor discharges, and work continues with the discharge quality improvement group and safeguarding partners to address this. A new named nurse has been appointed for safeguarding adults and safeguarding advisor into the adults team.
- *Children safeguarding:* work is ongoing with paediatric and mental health services to develop a children's mental health policy, a risk assessment tool and care plan to ensure patient safety and quality of care. Assurance has been provided to the CCGs that the recommendations from the class inspections of 2016 and 2018 have been actioned and where these are ongoing, that progress is being monitored. A new named midwife for safeguarding has been successfully recruited to, as well as a named Nurse for Safeguarding Children.
- *Mental Health*: Work continues in partnership with the Mental Health Trust and the service level agreement has been updated. Support has continued with mental health at tribunals

and with scrutiny and reporting mechanisms, and also supported the implementation of the new Mental Health Act paperwork.

- *Children looked after and care leavers (Calderdale):* Guidance at the start of the pandemic stopped the review of the health assessments and three members of the team were redeployed to support the delivery of acute services to Paediatrics and the PPE team. Every 18- to 25-year-old care leaver received a letter offering support around advice and public health.

DS commented on the strong report which included several key achievements over the past year and commended the safeguarding team for the work done. DS queried the training required for the implementation of the MCA and DoLS and asked if this will be able to be delivered. AE stated that a proposal is being drafted for the Board which will review the training which colleagues require. Work is currently underway with the CCGs to look at the implementation timescale, and a business case has now been completed for extra resources in the team to implement the liberty protection safeguards. There will be a period where liberty protection safeguards will work alongside deprivation of liberty.

AE was thanked for the update.

OUTCOME: The Quality Committee noted the annual report.

149/21 HIGH LEVEL RISK REGISTER

LR presented appendix E highlighting:

- 30 risks on the high-level risk register (two scoring 25; 10 scoring 20, 12 scoring 16 and six scoring 15)
- 10 existing top risks
- One new risk:
  - **8057**: *Risk of not achieving the Full Year 2021/22 Financial Plan* **(score 20)**
- Four risks removed since last update:
  - **7833**: *Increase in appointment slot issues (ASI) and holding lists*
  - **7803**: *Delay in general trauma surgery*
  - **8029**: *Open Maternity pathway*
  - **7617**: *Non-compliance with Data Security Protection Toolkit*
- One increased score risk:
  - **7328:** *Uncovered tier-one non-resident ENT* **(16 to 20)**
- One reduced score risk:
  - **7834:** *Elective orthopaedic inpatient theatre capacity* **(25 to 16)**

LR reported a change to the Risk Group, in that it now meets every other month, rather than monthly, providing an opportunity for further detailed work on individual divisional risk registers. There is also a piece of work ongoing across the divisions to look at describing some of the risks to ensure they are describing mitigations in a consistent way.

OUTCOME: The Quality Committee noted the report and approved the high-level risk register

150/21 INFECTION PREVENTION AND CONTROL REPORT – Q1

Dr David Birkenhead presented appendix F which relates to performance information for infection prevention and control during quarter 1 of 2021-2022, which has been reasonably positive. There has been an improved position over the same time last year, and regional data across the West Yorkshire Association of Acute Trusts (WYAAT) shows the Trust in a good position compared to other organisations, in relation to nosocomial infection.

OUTCOME: The Quality Committee noted the report.

EFFECTIVE

151/21 CLINICAL OUTCOMES GROUP REPORT

Dr David Birkenhead provided a verbal update on the work of the Clinical Outcomes Group, which is now well established and meeting monthly, with good representation. The terms of reference of the reporting sub-groups have also been reviewed to ensure that they meet the new standard template from the organisation.

The items of escalation to the Quality Committee from the last group include the Summary Hospital-level Mortality Indicator (SHMI) position, which has deteriorated over the last 18 months, with concerns of becoming an outlier. This was largely driven by the out of hospital SHMI position, and some work around same day emergency care (SDEC) patients which were included in the baseline but should not have. If those patients are removed, there will be a further deterioration in both the in-hospital and out of hospital SHMI position by around about four points, which would put the Trust in the 'worst' quartile. Since that meeting, there has been more information that reverses that, but does not take away the challenge in relation to SDEC, but there has been a rebasing of the SHMI position across the entire NHS, which improves the trust position by around about four points, so there will be an improved position moving forward. The total SHMI is just below 100, but as the SDEC patients are removed, and, if everything else remains the same, there will be no improvement, and can expect a deterioration of that position through the coming year. There is a lot of work ongoing to understand the causes, as well as seeking external support, and the work of the care of the acutely ill patient programme which has been re-established to focus both on how to improve the SHMI position in-hospital, but also to work with colleagues in primary care to look at those out of hospital deaths.

The other area to report on is nutrition and hydration. A common theme identified around documentation is compliance with the malnutrition universal screening tool (MUST) scores. A clinical lead for nutrition and hydration has now been identified who will now take this work forward with expert nursing colleagues.

Elizabeth Loney (Associate Medical Director) is now providing leadership with the Recommended Summary Plan for Emergency Care (ReSPECT) process and hoping to be implement over the coming 12 months. This will be in collaboration with Mid-Yorks, and our community partners.

DS enquired as to whether the external support has started. DB reported that Professor Mohammed Mohammed from Bradford University, who is a national expert on mortality metrics, has agreed to provide some support in relation to that external review. Colleagues from the informatics service have also been identified to support.

DB was thanked for the update.

152/21 HOSPITAL ONSET COVID INFECTIONS REPORT

Dr David Birkenhead presented appendix G, an overview of the governance arrangements for review of harm associated with hospital onset COVID infections (HOCI).

Maxine Travis (interim Risk Manager) and LR were acknowledged for the complex work put into the report, which looks at the number of hospital onset COVID cases in the organisation, the Trust's response to them and the learning in relation to them. There were 210 HOCI incidents overall, and whilst this is a high number, it is comparable to other organisations. The governance of the incidents was described in the paper, as well as the medical examiner review, structured judgement review, and the learning from incidents.

The NHS England and NHS Improvement (NHSEI) guidance note which is included in the appendix of the report will be implemented moving forward.

EA stated that the organisation will need a project management program approach to this with a co-ordinated and professional response, to ensure support processes are in place if this triggers a reaction.

OUTCOME: The Quality Committee noted the report.

153/21 LEARNING FROM DEATHS REPORT – Q1

Dr Cornelle Parker presented appendix H, providing assurance of the learning from deaths mortality review process.

In quarter 1, there were 351 adult inpatient deaths; 65 of those underwent initial screening review, representing 18% of the total, which is considerably short of the 50% target. The issue lies in elderly and respiratory medicine, as between them they account for nearly half - 46% of all inpatient adult deaths, and they are only reviewing 7% and 4% of their deaths, respectively. A recovery plan is being agreed at the moment.

OUTCOME: The Quality Committee noted the report.

RESPONSIVE

154/21 QUALITY REPORT

LR presented appendix I, providing the key points including:

- Care Quality Commission: Journey to outstanding reviews have taken place, and well-received by clinical teams. Thanks were conveyed to colleagues who helped support the implementation of the programme. Meetings with the CQC engagement team continue with reviews of the elective and outpatients recovery plan. There is still a 'must do' action that remains open but has substantial assurance and pending further consideration.
- Dementia screening: This remains significantly low and well-below target. Improvement activity is being undertaken by teams, particularly across both acute floors, surgical assessment unit (SAU) and the same day emergency care (SDEC) areas and including frailty and the clinical teams. New indicators on depression and delirium have also been introduced.
- Experience, participation and equalities: The patient experience and caring Group have continued to meet and prioritised key focus areas for the next six months.
- Complaints: Performance was at 94% in June and 68% in July, in terms of complaints closed within the timeframe. There is significant activity increase in patient advice and liaison (PALs), with 172 contacts in June and up 225 in July, and 47 compliments in June and 51 in July
- Incidents: The Committee's attention was drawn to the reduction in the number of open actions open for more than six months.
- Medication safety: There was a concert in the report this month around attendance and quoracy of the medicine, safety and compliance group. The barriers to attendance are required to ensure that the sub-group is sufficiently attended by colleagues.
- Maternity: A visit by the regional chief midwife and her team is expected, however a date is yet to be confirmed. Continuity of care remains a priority, and the Trust was successful in achieving funding for 10.9 midwives whole time equivalent (wte) and 0.2 wte consultant hours.
- Maternity staffing: the current percentage of 1:1 care in relation to NICE guidance on safe midwifery staffing and the provision of 1:1 care reported on the maternity services dashboard is 99.6% year to date
- Quality priorities:
  - *Sepsis* - there are a few areas of non-compliance with the sepsis 6 bundle, particularly around blood cultures and urine output, however, work continues to be undertaken
  - reducing waiting times in the emergency department - Continued to see an increase in some patients waiting over 12 hours, and some concern around the number of mental health patients that are waiting longer than that.

- The report includes detailed updates on the further focused quality priorities. It is anticipated that the next reporting period will include a heat map in order to view assurance at a glance. There have been some areas of improvement in pressure ulcers and further work being undertaken in falls. Nutrition and hydration, clinical prioritisation and clinical documentation remain a concern. There was a discussion at the weekly executive board (WEB) around the importance of critical documentation, with a further strengthened approach to that priority.

EA mentioned that clinical documentation is not just about clinicians documenting, it involves the electronic patient record and technical issues. It was suggested that there is a focus on clinical documentation alongside the optimisation strategies, and some work to be done to link the two.

OUTCOME: The Quality Committee noted the content of the report and the maternity update.

155/21 CANCER BOARD MINUTES

A copy of the cancer board minutes were available at appendix J for information.

156/21 INTEGRATED PERFORMANCE REPORT

Ellen Armistead reported on appendix K, that the safe domain is now amber, largely due to the never event. In terms of effective, this seems to be impacted by the fractured neck of femur access. The responsive domain is taking a bit of a hit due to the access target. The waiting list recovery is challenging, with huge increases in the accident and emergency attendances; a pattern that is being noted nationally. There are also high numbers of delayed transfers of care and backlogs in terms of care packages, and Community services are seeing a real increase in activity and acuity. Clinical prioritisation is well embedded now with a system of validating, and the Trust is currently supporting mid-Yorkshire with their non-surgical oncology challenges. Colleagues were signposted to the content of the strength, weaknesses, opportunities and threats (SWOT) analysis in the report.

OUTCOME: The Quality Committee noted the report.

POST MEETING REVIEW

157/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- Concerns on the stroke service at the moment and the need for further work to understand the current position and any development changes that need to take place going forward
- Updates from Business better than usual
- Updates on the safeguarding annual report
- A concern on clinical documentation, with discussion and agreement on more focused work around clinical documentation and linking to digital optimisation with a combined approach and clear that it is being addressed and covered appropriately
- Concerns on nutrition and hydration
- Update on the hospital onset COVID infection (HOCI) report and the sending of duty of candour letters shortly to relatives.

158/21 REVIEW OF MEETING

- More triangulation in terms of information, and focussing of where problems lie
- Comprehensive papers and good summary reports shared

159/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

160/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix L for information.

NEXT MEETING

Monday, 13 September 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 16 AUGUST 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS / ACTIONS DUE FOR NEXT MEETING				
19.07.21 (131/21)	**John Smith Stadium Community Vaccination Centre Paper**		Following presentation of the report, the Committee felt that the paper did not fulfil its purpose to assure that effective systems of internal control are in place. It was asked that a retrospective detailed closed-down quality assurance paper is provided. **Action 19.7.21**: That a final quality assurance paper is resubmitted to the Quality Committee. **Update 16.8.21:** This report will be available at the next Quality Committee meeting in September	**See agenda item 165/21**
CLOSED ACTIONS				
19.07.21 (133/21)	**Quality Committee Self-Assessment Results**	**All**	The Chair presented the results from the Committee's self-assessment which took place in April 2021. Whilst there was general agreement on many of the responses, there were a number of questions which resulted in a 'Strongly Disagree', 'Disagree' or 'Unable to answer' response. The results will form part of the Quality Committee's Annual report, and any further feedback or comments on the areas with responses 'Strongly Disagree', 'Disagree' or 'Unable to answer' will be valued. **Action 19.7.21**: Any comments on the responses from the self-assessment to be sent to DS by Monday, 26 July 2021 **Update 16.8.21:** No further comments received	**CLOSED 16 August 2021**
24.05.21 (90/21)	**IPR – Safer Programme**	Hannah Wood	DS also noted the challenges with increased numbers of patients coming through the ED and issues with the delayed transfer of care. EA stated that there needs to be more systems conversations in relation to the delayed transfers of care, as well as non-complex discharges. Throughout COVID-19, there were a set of 'must-do' actions which are now being reviewed, and one needs to be around patient flow, well-organised discharge and having plans in place over the weekend. There are still some improvements to be made internally about fundamental organisation of care. LR suggested that it would be useful for the presentation on the Safer Programme to come into the Committee. **Action**: Hannah Wood to be invited to the next Quality Committee to present the Safer Programme. **Update:** SAFER has had a launch meeting but not held its first board yet. A comprehensive update of the workstreams will be provided for the July meeting. **Action 19.7.21**: To be deferred to the next meeting **Update 16.8.21:** See agenda item 146/21	**CLOSED August 2021**
19.07.21 (134/21)	**Integrated Performance Report - Stroke**	Dr Pratap Rana	Following presentation of the IPR, the Committee felt that the response for stroke does not provide a description of the issues and requested that a representative from the Stroke team attends the Quality Committee to discuss. **Action 19.7.21:** Dr P Rana is invited to attend the Quality Committee to describe issues within Stroke. **Update 16.8.21:** See agenda item 146/21	**CLOSED 16 August 2021**

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 13 September 2021

STANDING ITEMS

161/21 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Lisa Cook **(LC)**	Head of Risk and Compliance
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Christine Mills **(CM)**	Public-elected Governor
Enzani Nyatoro **(EN)**	Interim Assistant Director for Patient Safety
Dr Cornelle Parker **(CP)**	Deputy Medical Director
Lucy Walker **(LW)**	Quality Manager, NHS Calderdale / NHS Greater Huddersfield / NHS North Kirklees CCGs
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Dr Elizabeth Loney **(EL)**	Associate Medical Director **(item 169/21)**
Dr Tahira Naeem **(TN)**	Consultant – Obstetrics and Gynaecology **(item 166/21)**
Philip Lewer **(PL)**	Chairman **(observing)**
Alexandra Keaskin **(AK)**	Corporate Matron **(observing)**
Laura Douglas **(LD)**	Matron - Maternity **(items 166/21 and 167/21)**

Lisa Cook, Alexandra Keaskin and Enzani Nyatoro were welcomed to their first meeting.

162/21 APOLOGIES

Karen Heaton **(KH)**	Non-Executive Director / Chair of Workforce Committee
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Karen Spencer **(KS)**	Associate Director of Nursing – FSS Division
Elisabeth Street **(ES)**	Clinical Director of Pharmacy

163/21 DECLARATIONS OF INTEREST

There were no declarations of interest.

164/21 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday 16 August 2021 were approved as a correct record. The action log can be found at the end of these minutes.

AD HOC REPORTS

165/21 JOHN SMITH STADIUM VACCINATION PROGRAMME

Dr David Birkenhead presented appendix C, providing a summary of the vaccination programme at the John Smith Stadium (JSS), which was an overall successful vaccination programme delivered through a mixed provider model. Despite some challenges, staff and public feedback and experience has been overwhelmingly positive.

Special thanks were conveyed to Asifa Ali (Research and Development Lead) and Elisabeth Street (Clinical Director of Pharmacy) for their efforts and to support to the JSS process.

OUTCOME: The Quality Committee noted the report.

166/21 MATERNITY INCENTIVE SCHEME

Laura Douglas and Tahira Naeem were in attendance to present appendix D, providing an overview of the requirements for year four of the Maternity Incentive Scheme.

The report describes the 10 safety actions which the Trust need to demonstrate can be achieved, and maternity services are in the process of setting up multi-disciplinary task and finish groups to ensure all elements within the 10 safety actions can be achieved by 30 June 2022.

The Chair asked whether any actions would be more challenging than others. **LD** stated that robust engagement across all services is required to achieve these actions, and that one of the initial challenges was the perinatal mortality review tool (PMRT) reporting, of moving from seven days to report eligible perinatal deaths, to two working days, however, immediate actions were taken to ensure that processes were in place. **LD** stated that the timescales for some of the actions may be challenging.

In relation to safety actions 4 and 5, the standalone midwifery staffing report to the Board of Directors was supported by the Quality Committee.

OUTCOME: The Quality Committee noted the report.

SAFE

167/21 MATERNITY REPORT

Laura Douglas and Tahira Naeem were in attendance to present appendix E, providing oversight of key quality issues within maternity services. The key points were:

- Maternity services continue to await notification of the date of the visit from the Regional Chief Midwife, following submission of evidence of compliance with the seven Immediate and Essential Actions from the Ockenden Report.
- The Trust have been successful in securing funding for 10.9 whole time equivalent midwives, in addition to current workforce models. The service is now in the process of recruiting to those positions. The service is aware that this will come with challenges, due to a national deficit of around 3000 midwives.
- The service has four continuity of carer workstreams and awaiting information from a paper submitted to the Scrutiny Board regarding a proposal to utilise the Huddersfield Birth Centre. The plan is dependent on the recruitment and retention of midwifery staff.
- Maternity incentive scheme, as highlighted at item 166/21.
- Maternity services noting a rise in stillbirth rates, particularly between January and June 2021, and as a result, a review of the 24 stillbirths which took place between 1 July 2020 and 31 June 2021 was undertaken. It was noted that 17 of the 24 women resided in Huddersfield, and 13 of those 17 resided in areas with an Index of Multiple Deprivation (IMD) code of 1 and 2. Four of the women resided in Halifax, and all those women had an IMD code of 1 and 2. The service is aware of the work required around women from areas of greater deprivation.

EA reported on concerns with the reality of being able to achieve the ambitions of continuity of carer, and the impact it would have on workforce. It has been agreed that across the Local Maternity Service (LMS), a proposal will be produced on what can be improved.

EA also noted that external validation by the regional midwife could take some time, therefore the LMS has agreed that the Lead Midwife will produce a proposal for peer reviews of services.

DB enquired about the stillbirth rates and asked if it was unusual for the increase and the amount of variation. **LD** felt that this was unusual, as the last noted high rate of stillbirths or

similar was in 2014, and since then, significant progress has been made in reducing the stillbirth rate at CHFT. It was queried whether COVID-19 played a part in the increase, however, there were no themes for such an increase, and it is not known whether women were impacted by COVID-19 prior to their loss. **TN** commented that there were no particular patterns for the reason for stillbirth, even though 33% of the women were smokers. The Saving Babies Lives recommendations state that every smoker should be offered regular growth scans, however, none of those women had growth restricted babies. Regardless of this, the service will take proactive action in reinstating scans for all smokers before it becomes a problem. It was also noted that there has been a rise in stillbirths across several organisations, however, it feels like a large increase due to CHFT rates previously being so low.

TN and **LD** were thanked for the report.

OUTCOME: The Quality Committee noted the report.

168/21 TRUST PSQB REPORT

This report will be deferred to the next meeting.

EFFECTIVE

169/21 CLINICAL EFFECTIVENESS AND AUDIT GROUP REPORT

Dr Elizabeth Loney was in attendance to present appendix G, updating on highlights from the Clinical Effectiveness and Audit Group (CEAG). Key points to note were:

- *Gaps in staffing* – there are a small number of vacant positions within the Group, however the team are continuing to carry out sterling work
- *NICE compliance* – monthly graphs, as detailed in the report, are now produced for divisions to depict trends in NICE compliance
- *Clinical audit bubbles* – a proposal for learning from audits to be shared more effectively through bubbles, indicating why the audit was carried out, what was done, what was found and what will happen next. Clinical audit leads are required to summarise appropriate audits into the four areas.
- *National data opt-out* - the deadline for health and care organisations to comply with national data opt-out has now been extended to 31 March 2022, and CHFT implementation is being led by the Information Governance team.
- *Clinical Audit Competition* – a competition was run during Clinical Audit Awareness Week in November 2020. A decision has been made nationally to defer the next Awareness Week until the spring of 2022, however, there is a recommendation to run the competition again this year
- *Clinical Audit Leads* - clinical audit leads now attend the CEAG on a rotational basis to gain an insight into what takes place with clinical audits and national guidance.
- *Consent Group* – this Group is due to be reinstated, with a plan for the first meeting to take place on 14 October 2021.
- *Audit summary report* – following a 'go see' to a regional audit group, Barnsley Hospital Trust shared their clinical audit summary report in which they included levels of assurance into the report. It has been agreed that this would be incorporated into the CHFT clinical audit summary reports.

EL was thanked for the positive report and evidence of work taking place.

OUTCOME: The Quality Committee noted the report.

RESPONSIVE

170/21 INTEGRATED PERFORMANCE REPORT

Ellen Armistead reported on appendix H, highlighting the increased number of non-elective attendances and the running of the recovery programme which is currently challenging, due to the sickness absence rate and staffing availability and capacity. Work is being undertaken

with partners to look at a system approach to the current pressures faced. There was an increase in complaints and concerns through the Patient Advice and Liaison Service (PALS), and an increase in complaints relating to visiting restrictions, which are currently under review. A spot-check will be carried out to ensure that restrictions are being applied appropriately and meets the needs of families and carers, as well as the Trust Infection, prevention and control guidance. In relation to safety, there will be a section within the hard truths report at the next Public Board of Directors, on the link between the increase in falls and pressure ulcers and a decrease in available care hours per patient day.

The Chair stated that over the last 12 months, there has not been an improvement in the Methicillin-resistant staphylococcus aureus (MRSA) elective screening and asked if there were any particular reasons for this. **DB** stated that this may relate to the elective care situation at the moment, however, it is being followed up through the infection, prevention and control (IPC) performance and IPC Gold meetings.

The Chair stated that return-to-work interviews are at their lowest rate since January 2021 and asked if this was linked to the retraction of support from Workforce and Organisational Development (WOD) team to divisions. **JE** stated that the data is indicative of a catch-up period, therefore all the reporting period information is not captured, therefore, data is being retrospectively updated. **JE** also stated that it is less of a withdrawal from WOD team, and more of WOD providing additional coverage and support of divisional teams who may not be able to complete the activity and is evidently an issue in the timeliness of reporting into the Electronic Staff Record (ESR). Consultation with divisional colleagues is taking place on what activities can be taken from divisional colleagues, in order to not see a decrease in reporting activity. Completion of return-to-work interviews are around 80% and this level is hoping to be sustained.

OUTCOME: The Quality Committee noted the report.

171/21 SUB-GROUP TERMS OF REFERENCE

The Clinical Outcomes Group terms of reference were circulated at appendix I for ratification.

OUTCOME: The Quality Committee approved the terms of reference.

POST MEETING REVIEW

172/21 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- The JSS vaccination programme close-down report
- The Maternity Incentive Scheme report
- The Maternity update report on the increases in stillbirth rates
- The Integrated Performance Report
- The Clinical Effectiveness and Audit Group report

173/21 REVIEW OF MEETING

There were no updates.

174/21 ANY OTHER BUSINESS

There was no other business.

ITEMS TO RECEIVE AND NOTE

175/21 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at Appendix J for information.

NEXT MEETING

Monday, 11 October 2021 at 3:00 – 4:30 pm on Microsoft Teams

QUALITY COMMITTEE ACTION LOG FOLLOWING MEETING ON MONDAY, 13 SEPTEMBER 2021

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE / CLOSED DATE / RAG RATING
OPEN ACTIONS / ACTIONS DUE FOR NEXT MEETING				
There were no new actions at the September 2021 meeting.				
CLOSED ACTIONS				
19.07.21 (131/21)	**John Smith Stadium Community Vaccination Centre Paper**		Following presentation of the report, the Committee felt that the paper did not fulfil its purpose to assure that effective systems of internal control are in place. It was asked that a retrospective detailed closed-down quality assurance paper is provided. **Action 19.7.21**: That a final quality assurance paper is resubmitted to the Quality Committee. **Update 16.8.21:** This report will be available at the next Quality Committee meeting in September **Update 13.9.21:** See item 165/21	**CLOSED 13 Sept 2021**

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 12 October 2021 commencing at 10:00 am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Kirsty Archer	Deputy Director of Finance
Helen Kemp-Taylor	Head of Internal Audit, Audit Yorkshire
Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
Jim Rea	Managing Director, Digital Health
John Gledhill	Public Elected Governor – Lindley and the Valleys
Clare Partridge	External Audit Partner, KPMG
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Amber Fox	Corporate Governance Manager (minutes)
Helen McNae	Data Protection Officer **(for item 69/21)**
Zoe Quarmby	Financial Controller – Finance
Elizabeth Loney	Associate Medical Director and Consultant Radiologist **(for item 70/21)**

65/21 APOLOGIES FOR ABSENCE

Apologies were received from Gary Boothby and Philip Lewer.

The Chair welcomed everyone to the Audit and Risk Committee meeting, in particular Jim Rea, Managing Director for Digital Health, John Gledhill, Public Elected Governor, Helen McNae, Data Protection Officer and Elizabeth Loney, Associate Medical Director.

66/21 DECLARATIONS OF INTEREST

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

67/21 MINUTES OF THE MEETING HELD ON 21 JULY 2021

The minutes of the meeting held on 21 July 2021 were approved as a correct record.

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 21 July 2021.

68/21 ACTION LOG AND MATTERS ARISING

The action log was reviewed, only one action is outstanding around the internal audit follow up report which will remain ongoing.

AN asked if the action regarding the Audit and Risk Committee terms of reference can be captured on the action log.

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

69/21 INFORMATION GOVERNANCE DEEP DIVE

Helen McNae, Data Protection Officer presented a deep dive on Information Governance and highlighted the priorities over the next 12 months as follows:

1. Data Security and Protection Toolkit (DSPT) compliancy
2. Corestream Asset Management System – to build the system and embed in the Trust
3. National Data Opt Out (NDOO) compliancy

The Data Security and Protection toolkit is a self-assessment tool to measure compliance with a series of assertions and evidence against ten data security standards including confidentiality, data security, information governance, staff training and policies. The mark is either a pass or a fail, with non-compliance in one standard leading to non-compliance for the whole toolkit. The Data Protection Officer confirmed the Trust achieved compliance across all assertions.

A priority over the next few months is to build the Corestream asset management system which is a significant task. Corestream will enable the Trust to have better control of its information assets with the initial scope being focussed on databases and information systems. There is also functionality to manage freedom of information requests on Corestream which is being explored.

The NDOO process has already been put in place with a deadline of 31 March 2022 for compliance. The national data opt out gives service users and patients the opportunity to opt out of their information being used for example in research, planning, and surveys.

The Data Protection Officer described the areas which are going well:

- Colleague engagement to achieve our information governance goals
- Confidence in meeting the DSPT requirements and remaining compliant this year
- Governance arrangements in place

The areas requiring improvement were:

- Communications - need to improve the content of the communication for asset owners and administrators
- Assigning ownership of DSPT assertions
- Awareness and knowledge of the NDOO.

RH asked if there have been issues historically in achieving the training compliance for DSPT and what had changed to achieve this compliance. The Data Protection Officer responded that this was due to communication and managers taking responsibility to ensure each team is compliant. The requirement is to achieve 95% of compliance on one day over the course of the year which CHFT has done.

RH asked for an update on the incident from the IG Group summary report of 14,000 patient letters that didn't get sent out and if this was rectified. The Data Protection Officer explained this issue was raised by the data quality team. The Managing Director of Digital Health explained there was an issue with Cerner on some of the letters not being sent out which happened over a period of 8 months. This was captured within the team and an audit showed 14,000 letters had not been sent out. The Chief Operating Officer was involved in this work and all letters were reviewed and re-sent. There is an ongoing review into whether there was any patient harm. The Managing Director for Digital Health confirmed the technical issue was resolved by Cerner and a weekly report is produced and is now pro-actively checked to understand how many letters have failed.

DS added that a report from Neil Staniforth was received at the Quality Committee this month and a further report will go to the next Quality Committee to understand if there has been any patient harm due to the delay.

AN asked for an update on the progress in identifying information asset owners. The Data Protection Officer explained the asset owners are being contacted to ensure they are still the right people. She added that communication and training need to be re-addressed.

AN recognised that freedom of information requests (FOIs) has become a challenge to respond to and are increasing in numbers. The Data Protection Officer confirmed an FOI Improvement Group has met and the new system Corestream will help streamline FOIs and automate reports.

AN asked if the Patient Portal is getting more actively used and, or creating more challenges for us as a Trust. The Data Protection Officer stated there is a good uptake in the use of the patient portal compared to most other Trusts. However, there remain challenges in access for those under the age of 16. The last IG Group looked at options to address this issue.

OUTCOME: The Committee **NOTED** the details provided in the Information Governance Deep Dive presentation and the priorities over the next 12 months.

70/21 CLINICAL AUDIT UPDATE

Denise Sterling introduced Elizabeth Loney, Associate Medical Director, who was in attendance to present an update on clinical audit. DS explained lots of good work has taken place for clinical audit resulting in good outcomes and strengthened processes.

The Associate Medical Director explained the huge number of audits that take place with more than 500 registered audits both national and local audits. During Covid, a lot of the audit programme was put on hold; however, audit work has now restarted. There have been significant staffing gaps in the audit team and a few vacancies which are being filled. She added that several audit leads have been replaced.

The first Clinical Audit Competition took place in November 2020, attracting a large number of high-quality submissions from medical, nursing and Allied Health Professional (AHP) staff. The top four audits were judged by peer review and presented live on Microsoft Teams to a wide audience, thus disseminating learning. Two of the top four submissions were subsequently accepted for presentation at a National Audit Meeting.

Although the National Clinical Audit Awareness week has been cancelled this year, CHFT have decided to go ahead with "*CHFTs Audit Competition 2021".* Audits completed between 1 October 2020 and 30 September 2021 will be eligible for submission. Four audits will be selected for presentation via a Trust wide virtual audit meeting. Everyone who submits an audit will receive a Certificate of Participation and those selected for presentation, a Certificate of Excellence. The provisional date set for this is Thursday 25 November. A communication on this will be going out in CHFT News.

Clinical Audit Leads and the Governance Team are developing 'Audit Bubbles' to summarise clinical audit outcomes in an easy-to-read, concise manner, with plans to launch an 'Audit Bulletin' every six months in the near future. The audit bubbles are a way of sharing learning with colleagues.

The first Clinical Audit Leads meeting took place in January 2021 and received positive feedback. Discussions at the first meeting included the importance of having a project plan and action plan for each clinical audit, and ways of assisting clinical audit leads in preparing their annual audit plan. Two further meetings have been held since and have been well attended.

The Associate Medical Director explained the NDOO applies to a few national audits and it is challenging to know if patients have opted out. The impact this will have on clinical audit has been assessed and discussed with Information Governance resulting in an agreed Standard Operating Procedure (SOP) which is now in place.

An internal audit review of clinical audit has taken place which reported a rating of 'significant assurance'. The actions arising from this have gone back to the clinical audit leads meetings to be addressed.

Trust audit priorities based on the Annual Report and Quality Standards are shared with Audit leads to increase alignment of clinical audits performed in the Trust with quality priorities.

The Associate Medical Director highlighted audits where there is a lack of contribution:

- National inflammatory Bowel Disease (IBD) registry – unable to take part due to staffing pressures. The clinical audit team are working with the National IBD team to find a resolution to submitting an audit
- National diabetes audit – Predominately a Primary Care Audit and only contributing minimally and the plan is to discontinue this audit in future

AN asked if the 'Audit Bulletin' is ready to be launched. The Associate Medical Director confirmed this will be ready for next year.

AN asked what the mechanism is to check that learning has been embedded. The Associate Medical Director responded that recommending actions from national audits are checked through snapshot audits six months later which use a selection of patients to review progress. Local audits wait until the re-audit for assurance.

AN asked how the clinical audit programme benchmarks against other Trusts. The Associate Medical Director explained lots of these are local audits and it is only the national audits against which we could benchmark our performance. She explained one of the issues is keeping track of all the audits and the team are looking to get an excel spreadsheet into Knowledge Portal to enable improved reporting and deep dives into the audits.

RH stated he is satisfied with the progress made.

John Gledhill highlighted Locala not participating in the audits. He asked if the Trust accepts this or engages in dialogue with Locala. The Associate Medical Director explained different contracts are being reviewed to understand what processes are in place and when this contract is up for renewal the requirement to participate will go in the new contract if it is not already included.

DS commented she is pleased to see work is underway to align audits to quality priorities and said it will be interesting to see how successful this has been in the report next year. The Associate Medical Director confirmed the list of Trust priorities for quality and safety are sent out to all audit leads to ensure their audit plans align with them.

OUTCOME: The Committee **NOTED** the update on clinical audit.

71/21 ACCESS TO CLINICAL RECORDS ACTION PLAN UPDATE

Jim Rea, Managing Director for Digital Health provided a verbal update on the clinical records action plan and explained they are currently streamlining the process for auditing unauthorised access with a tool to link to the active directory.

AN asked for an update on what the data is telling us as previously the Committee have received encouraging reports confirming that we are not seeing inappropriate access.

The Managing Director for Digital Health confirmed that no inappropriate access is taking place and it is almost always relating to how long the patient has been in the Trust resulting in more access. He added that the more intelligent reporting tool will give a more informed and proactive view on record access.

AN agreed that given this positive assurance this matter no longer needs to be escalated to the Audit and Risk Committee as it will be report into the Information Governance and Records Strategy Group.

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

72/21 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments

Zoe Quarmby, Financial Controller presented a report summarising the losses and special payments for quarter 2 2021/22. The key points to note were that

- £280k losses and special payments have been incurred during Q2
- Bad debt write offs are included on the register following approval at the Audit and Risk Committee in July to a total of £230k, of which £190.6k related to overseas visitors
- Huddersfield Pharmacy Specials (HPS) – Q1 value has been restated from £47.9k to £63.4k which were additional production losses in HPS
- Loss of personal effects of £3.64k covers seven claims
- Losses of £6.9k is the net of three claim payments paid for excess on public/employers liability claims / NHS Resolution
- Special payments ex-gratia of £2.44k were for care fees following a complaint which has been through the Medicine Division and Quality and Risk
- Compared to the average quarterly value of losses and special payments in 2020/21, there is a 129% increase at Q2 2021/22 due to bad debt write off

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

2. Review of Waiving of Standard Orders

The Finance Controller presented the quarter report showing a total of six waivers during this quarter period, totalling £136,922.

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

73/21 INTERNAL AUDIT

1. Internal Audit Follow Up Report

The Internal Audit Manager presented the follow up report which sets out the Trust-wide position on the implementation of Internal Audit recommendations due during Q2 2021/22.

The Internal Audit Manager explained a follow up discussion on open and overdue recommendations took place at the Weekly Executive Board (WEB) in August. She explained a process is now place for Internal Audit to attend WEB in advance of Audit and Risk Committee meetings to tackle the overdue recommendations.

The changes to the follow up report were highlighted which now shows 12 months of data, any overdue recommendations that remain open and how many are completed. A total of 36 recommendations remain overdue due to timings and responses are being followed up. Nine of the overdue recommendations relate to the audit of Consultant Study Leave and eight to the audit of Delegated Consent. Target dates for these recommendations have been revised to April 2022 due to Covid-19 pressures.

RH was pleased to see the regular involvement at WEB. He noted the changes to the reporting process and highlighted that 16 recommendations remain open from 2017/18 and 2019/19 and 2019/20 and expects a number of these to be cleared by December 2021. He noted the ongoing option to invite the relevant sponsor leads to the Committee if these don't progress.

The Internal Audit Manager asked for any feedback on the new style report and the Committee fed back they are happy with the new format. She explained there is pressure in getting some of these audits cleared and the team will be looking for support from the Acting Director of Finance.

The Acting Director of Finance agreed and stated the route into Executive Board is a good plan. She explained it would be useful to have the information in advance of Executive Board to undertake some preparation.

The Internal Audit Manager has started a benchmarking exercise on recommendation tracking which will be reported in January 2022.

AN raised his concern on the numbers of major recommendations which now have revised dates. AN agreed to write to the Acting Director of Finance and the Medical Director to describe the expectation of the Audit and Risk Committee for review at the next meeting in January 2022.

Action: AN to contact the Acting Director of Finance and the Medical Director to re-emphasis the Audit and Risk Committee expectation.

2. Internal Audit Progress Report

The Head of Internal Audit presented this report which details the progress made by Internal Audit in completing the Internal Audit Plan for 2021/22. A total of five audit reports have been agreed since the July 2021 meeting and one further report has been issued in draft. There are:

- 3 'high assurance' reports
- 2 'significant assurance' reports
- 1 'limited assurance' report remains in draft.

The Internal Audit Manager explained the plan is slightly behind due to starting later than normal due primarily to completing the four audits carried over from the 2020/21 plan. She explained that July and August have been challenging in terms of internal audit and Trust staff availability.

In terms of delivery the Head of Internal Audit (HIA) stated they are expecting the plan to be delivered and CHFT has had the best engagement in their plan across all Audit Yorkshire clients which is very positive.

AN stated he feels the plan is behind schedule but was pleased to get assurance from the HIA about completion of the plan. Progress will be reviewed again in January 2022, given Trust pressures will continue, to see if audits need to be re-prioritised to ensure a HIA opinion can be given. The HIA responded that some of the work is being brought forward with good engagement from CHFT in doing this.

OUTCOME: The Committee **APPROVED** the Internal Audit Follow Up Report and Progress Report and **RECEIVED** the significant and high assurance reports and the Insight reports for July and August 2021.

74/21 EXTERNAL AUDIT

1. Sector Technical Update

From the Sector Technical update, the External Audit Partner, KPMG highlighted the health and care bill and the structure of the Clinical Commissioning Groups (CCGs) merging into the Integrated Care Boards. She explained the required legislation may not be approved by 31 March 2022 as expected.

In relation to the update on NHS holiday pay for voluntary overtime, RH highlighted the importance of including the accruals for the required adjustment and accounting treatment. The Acting Director of Finance explained this refers to the Flowers case, where there was a national allocation of £0.5m of funding which was notified at the end of 2020/21. The backdated element and one-off payment has gone through in this year and requires onward calculation. The External Audit Partner added that this also impacts the care sector where there is more voluntary overtime.

Action: Acting Director of Finance to clarify with HR/Payroll if the onward calculation has been applied.

In relation to the update regarding the NHS staff pay rise, the Acting Director of Finance confirmed the 3% pay rise is included in the 2021/22 budget and has been paid for all staff with a backdated element and will be applied going forward routinely in monthly pay. The funding for the one-off element and future recurrent is to be incorporated in the H2 funding allocations. The plan is to accrue a level of income in to compensate for the one-off payment and to anticipate the inflation rate in the H2 funding allocation.

2. Benchmarking Q1 2021-22 Report

The External Audit Partner, KPMG presented the benchmarking Q1 report for aspects of finance management information and highlighted areas where CHFT are different to peers based on the data.

The External Audit Partner, KPMG highlighted the Covid expenditure graph and spend compared to others for total staff costs and total non-pay expenditure is reasonably high compared to others.

The Acting Director of Finance responded that the Covid element of expenditure is difficult to benchmark as there is an element of judgement in terms of what constitutes Covid and other non-emergency care. She explained there is detailed categorisation of what we could count as Covid expenditure e.g., streaming in A&E, Covid and non Covid patients and the staffing element required. She added that CHFT have two A&E departments whereas other Trusts may only have one. She added that the Trust purchased Personal Protective Equipment on behalf of the region including a high volume of gowns.

The Acting Director of Finance stated the threshold for achieving elective recovery funding in the first quarter of the year was relatively low and then increases month on month. A total of £3-3.5m of funding was received related to elective recovery funding and the spend came later when the targets became harder to achieve whilst thresholds increased in July. The External Audit Partner, KPMG highlighted the Trust still achieved significantly better than plan. The Acting Director of Finance confirmed the Trust are on plan to achieve breakeven by Q2.

RH highlighted the benchmarking last year was close to average and he was surprised it was higher during this time. He highlighted the better performance on payment days to suppliers which he expected to see improved as a result of the cash and debt position.

The Acting Director of Finance pointed out the Covid expenditure appears high and explained the level of funding embedded which relates to Covid doesn't change according to the spend. The Regional Director of Finance and NHS Improvement colleagues were encouraging more thorough Covid expenditure reporting as these costs continue.

OUTCOME: The Committee **NOTED** the technical update and the CHFT Benchmarking Q1 Report 2021-22.

74/21 LOCAL COUNTER FRAUD PROGRESS REPORT

1. Local Counter Fraud Progress Report

Shaun Fleming, Local Counter Fraud Specialist presented the Local Counter Fraud progress report. The key points to note were:

- International fraud awareness week is coming up and the need to promote this
- Quarterly newsletter is available in the review room on Convene
- Fraud Prevention master classes (1 hour) have been taking place across all clients focused on high-risk fraud issues such as payroll. Staff attendance is starting to increase and they are continuing to encourage staff to apply for these classes
- Prevent and deter fraud alerts are included in the report which shows a common theme of cyber crime
- National Fraud Initiative (NFI) has commenced
- Strategic governance – the Counter Fraud Authority has undertaken a review CHFTs compliance to on the new NHS standards resulting in a score of amber. Only one percent of Trusts came back as red nationally. There is a plan for CHFT to move to green for the next counter fraud functional return April-March 2022.
- Fraud Prevention Guidance Impact Assessment (FPGIA) look at outcomes and work undertaken on fraud alerts and there is a plan to produce the submission for the Trust by the December 2021 deadline.
- Covid-19 post event assurance exercise (Procurement) – the Trust submitted evidence around this. The National Counter Fraud Authority will analyse the date and provide guidance on lessons learned.

RH asked are there any fraud cases within the Trust at the current time. The Local Counter Fraud Specialist responded there is nothing substantive to report. The number of referrals has dropped nationally since Covid and cyber crime may have become the prevalent issue.

2. Review Counter Fraud Policy

The Local Counter Fraud Specialist presented the Counter Fraud Policy. The key changes to the policy were:

- Changed the wording to ‘Counter’ Fraud
- Reflecting the advent of the new functional standards
- Included the role of the fraud champion which is being developed.

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

75/21 BOARD ASSURANCE FRAMEWORK

The Company Secretary presented the second update of the Board Assurance Framework (BAF) for 2021/22 which showed the changes made in red.

There has been minimal change to the risk profile and no new strategic risks have been added. The movement in risk scores primarily reflect operational pressures.

The score for risk 11/19 regarding recruitment and retention was reviewed. There has been no risk score increase as at present there has only been minimal impact on retention.

RH noted on the heat map risk 06/19 is showing as a score of 20 and should now be 15.

RH explained the Finance and Performance Committee approved the increase in the Covid-19 risk, 5/20. He added that the commercial risk may potentially increase due to perceived performance issues at HPS which was discussed at the HPS Board; however, it has been agreed that this risk score would not change at the current time.

AN highlighted the risk 01/20 clinical strategy has a downward arrow on the heat map when it should be an equals sign.
Action: Company Secretary to correct the risks on the heat map (06/20 and 01/20)

The Company Secretary confirmed the Risk Appetite Statement has been updated and the wording for the representation and partnership categories was approved at the Board in September 2021.

AN stated it is a better set of updates for all of the risks and the risk score movement is good to see as it feels more active use is being made of the BAF. He stated there are a number of risks with rigorous assessment of gaps and actions and some which require more work.

RH pointed out risk 06/19 is shown under the risk appetite for regulation as opposed to harm and safety. The Committee discussed this and agreed the regulation category remains appropriate.

OUTCOME: The Committee **NOTED** the updated Board Assurance Framework as at 4 October 2021, noting the movement in risk scores and areas of risk exposure.

76/21 COMPANY SECRETARY'S BUSINESS

1. Declaration of Interests and Standards of Business Conduct Register Month 6 Update

The Company Secretary presented the month 6 report for 2021/22 which details the current position on compliance with declarations of interest in line with the Trust's Conflicts of Interest and Standards of Business Conduct Policy to the end of September 2021.

The report shows improvement have been made compared to 2020/21. The most used declarations other than nil declarations are clinical private practice and other employment.

The Company Secretary stated it is re-assuring to see the figures and stated reminders continue to be sent out. The requirement to submit an annual declaration is part of the appraisal process which runs to the end of October 2021.
AN highlighted a small difference in the numbers in the tables on page two, 583 compared to 587.

Denise asked if the prompt at appraisals is a reminder and not a mandated step in the appraisal process for the appraisee. The Company Secretary confirmed it is not a mandated step in the appraisal process but part of a list of questions and brings the requirement to their attention.

OUTCOME: The Committee **NOTED** the month 6 declarations of interest and standards of business conduct register report.

2. Review Audit and Risk Committee Workplan 2022

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

OUTCOME: The Committee **APPROVED** the Audit and Risk Committee workplan for 2022.

77/21 EXTERNAL AUDIT APPOINTMENT

The External Audit Partner, KPMG left the meeting at this point due to a conflict of interest.

The Company Secretary presented the appointment of external audit paper summarising the work of a group convened for the procurement of an external auditor. She explained the Audit and Risk Committee are asked to support the recommendation for appointing KPMG for the next three years with the option for a one year extension, with the fees detailed in the paper. KPMG were the only firm from the government approved procurement framework CHFT used to express an interest in undertaking the audit.

RH stated it is the first time he as seen a 100% increase in fee being quoted; however, he was aware audit fees generally are going up substantially. He acknowledged there is no alternative at this stage unless the process was extended to go out to full tender; however, this isn't practical given the timescale. Feedback was given that other Trusts are paying a similar amount at the current time. RH was not content with a three year appointment and option for a one year extension but he accepted the position.

The Audit and Risk Committee noted the concern about the level of increase in the fee.

AN expressed the same view as RH and approved the recommendation with reluctance, noting he had challenged Stuart Baron, the Associate Director of Finance to understand the basis of the proposed fees and was assured there was no alternative.

The Acting Director of Finance acknowledged the increase in fees and stated this has been flagged during calls nationally therefore a fee rise was expected. She added the length of the contract will be a benefit, not just financially but also operationally due to the knowledge the current auditors have of the wholly owned subsidiary and our reconfiguration plans.

DS highlighted her concern in the rise in fees but recognized the continuity benefits highlighted by the Acting Director of Finance.

The Company Secretary assured the Committee they have tried negotiating with KPMG who have applied national fee rates.

The Acting Director of Finance explained that given the increase in fee the Trust need to ask for the correct level of dedicated resource from KPMG given the problems that had been experienced signing off the 2020/21 accounts.

OUTCOME: The Committee **SUPPORTED** the recommendation to appoint KPMG, subject to ratification by the Council of Governors.

78/21 SUMMARY REPORTS AND MINUTES TO RECEIVE

A summary report of work undertaken since July 2021 was provided for the following groups and minutes of these groups were made available in the review room on Convene:

- Risk Group – no questions were raised.
- Information Governance and Records Strategy Group – no questions were raised.
- Health and Safety Committee – no questions were raised.
- Data Quality Board – no questions were raised.
- CQC and Compliance Group – no summary report was received due to a timing issue.

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

79/21 ANY OTHER BUSINESS

There was no other business.

80/21 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- ***Acknowledge*** – achievement around the DSPT toolkit and work on clinical audit
- ***Assurance*** – approval of the Board Assurance Framework with further work still needed on some risks and approval of the Counter Fraud Policy
- ***Awareness*** – Internal Audit recommendations have made some progress; however, the Committee want to see older recommendations cleared. The Committee reluctantly supported the recommendation to appoint KPMG despite the fee rate rise as only one bid was received.

81/21 DATE AND TIME OF THE NEXT MEETING

Tuesday 25 January 2022
10:00 – 12:15 pm
Microsoft Teams

82/21 REVIEW OF MEETING

The meeting closed at approximately 12:00 pm.

Appendix A

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

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

Held on Thursday 30 September 2021, 3.15pm – 4.1pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Deputy Chief Executive/Director of Nursing
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Karen Heaton	(JH)	Non-Executive Director (Chair)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Andrea McCourt	(AM)	Company Secretary
Helen Senior	(HS)	Staff Side Chair

IN ATTENDANCE:

Errol Brown	(EB)	Category Manager/Chair, BAME (for agenda item 91/21)
Nikki Hosty	(NH)	Assistant Director of HR (for agenda item 98/21)
Mike Lucraft	(ML)	Chair, Trust's Disability Action Group (for agenda item 91/21)
Jackie Robinson	(JR)	Assistant Director of HR (for agenda items 90/21 and 97/21)

85/21 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

86/21 **APOLOGIES FOR ABSENCE**

Mark Bushby, Workforce Business Intelligence Manager
Denise Sterling, Non-Executive Director

87/21 **DECLARATION OF INTERESTS**

There were no declarations of interest.

88/21 **MINUTES OF MEETING HELD ON 9 AUGUST 2021**

The minutes of the Workforce Committee held on 9 August 2021 were approved as a correct record.

89/21 **ACTION LOG – September 2021**

The action log, as at 30 September 2021, was received.

90/21 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – SEPTEMBER 2021**

JR presented the report.

Performance on workforce metrics is now amber and the Workforce domain at 67.4% in August 2021. This has remained in the amber position for a second month. 4 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)', and Data Security Awareness EST compliance. Medical appraisals are currently not included in the overall Domain score due to the current Covid-19 pandemic.

Workforce – August 2021
The Staff in Post decreased by 3.00 FTE, which, is due, in part to 28.97 FTE leavers in August 2021. FTE in the Establishment figure decreased by 17.30, along with student nurses leaving.

Turnover decreased to 7.98% for the rolling 12 month period September 2020 to August 2021. This is a slight decrease on the figure of 8.13% for July 2021.

Sickness absence – August 2021
The in-month sickness absence increased to 5.59% in August 2021. The rolling 12 month rate also increased marginally for the twenty third consecutive time in 33 months, to 4.76%. Anxiety/Stress/Depression remains the highest reason for sickness absence, accounting for 35.73% of sickness absence in August 2021, increasing from 35.30% in July 2021.

The RTW completion rate decreased to 60.26% in August, down from 64.61% in July 2021. This is the second consecutive monthly decrease and is below target.

Essential Safety Training – August 2021
Performance has decreased in all the core suite of essential safety training. With 10 out of 10 above the 90% target and 2 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 93.93% and is the second decrease for 2 months. It is however still also above the stretch target of 95.00%.

Workforce Spend – August 2021
Agency spend increased to £0.47M, whilst bank spend increased by £0.79M to £3.43M.

Recruitment – August 2021
2 of the 5 recruitment metrics reported (Vacancy approval to advert placement, and Pre employment to unconditional offer) improved in August 2021. The time for Unconditional offer to Acceptance in August 2021 increased and was 2.6 days.

JR highlighted in particular the strong EST performance across all 10 modules given current staffing challenges. A concern was noted regarding decreased compliance rates in Data Security. SD confirmed the Managing Director for Digital Health (previously Mandy Griffin, now Jim Rea), and operational HR have developed a plan to tackle non-compliance but also acknowledged the huge pressures on colleagues.

KH asked about progress in international recruitment. JR confirmed this matter is included within the Nursing Workforce Programme update later in the agenda.

KH noted that sickness absence rate although at a slower rate had increased further in August with stress and anxiety being the main reason for last 18 months.

The Committee noted the significant decrease in RTW rates. JR advised the HR operational team have implemented supportive measures to increase completion rate.

KH thanked everyone for their hard work particularly over the last 18 months.

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

91/21 **WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES)**

The Committee received the WRES and WDES annual workforce data and associated action plan. Analysis of 2020/2021 and previous years' data, along with the reality of the pandemic resulted in the action plans giving focus on more virtual interaction and more online education

and awareness. Both action plans will be monitored by the Inclusion Advisory Group on a bi-annual basis along with regular discussion at all the Trust's Equality Groups.

WRES
EB provided an overview of the data and action plan and outlined the successes over the last 12 months. Key actions will focus on:-

- Increasing number of BAME colleagues
- Recruitment processes
- Leadership, training and development opportunities
- Digital inclusion
- Rooting out racism

EB thanked everyone for their support and in particular NH. KH asked if there was a good cross section of colleagues attending the groups. EB explained the BAME network is very inclusive, offering colleagues a safe platform and encourages colleagues from lower bandings to come forward.

WDES
ML presented an overview of the action plan. The Trust's Colleague Disability Action Group was instrumental in the development of the action plan, key actions will enable:-

- Improved declaration rate for disability status
- Positive impact on recruitment of disabled colleagues
- Reduced harassment, bullying and abuse
- Career development opportunities
- Involvement in review of employment policies

ML believed the biggest areas of progress is the formation of colleague network groups. KH asked about attendance at the group. ML would like to see more colleagues involved in these platforms that create opportunity to push forward change.

JE commended ML, EB and Rachel Newburn, Chair of LGBT+ group for their strong advocacy in engaging others and NH for leading on expansion of the network groups.

KH celebrated the remarkable achievements and welcomed a 6-month progress update.

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

92/21 **BOARD ASSURANCE FRAMEWORK**

EA presented a deep dive into BAF risk 10b Nurse Staffing. EA confirmed the risk remains relevant and is reflective of the current position. Further key controls such as twice daily staffing meetings, daily and weekly nurse staffing escalation reports and bank enhancements have been introduced. Additionally, a Worry Area Dashboard has been created and is presented to Gold Command to inform the discussion on staffing pressures. The report states that the combination of managing covid positive and negative patients, increase in non-elective activity, staff sickness (covid and non-covid related), elective recovery and a decrease in staff undertaking bank shifts is significantly impacting on safe staffing levels. Assurance processes are in place and reflect good practice, however the reality remains filling shifts is significantly challenging.

The ability to measure the impact has significantly improved over recent days and upon receipt of the refreshed Dashboard, EA proposes the risk rating score is increased to 20. The Committee is supportive of the proposal.

KH asked if colleagues were able to take their wellbeing hour. EA advised of inconsistency across that patch. Colleagues are grateful the wellbeing hour is available even if they are not able to take it. SD confirmed senior visibility is having a positive impact. JE referenced the pay enhancement scheme advising that checks are in place to safeguard colleagues working beyond contracted hours.

OUTCOME: The Committee **NOTED** the report and supported increase in score.

Post meeting note: AM advised the score will remain at 20 noting the current significant impact on safe staffing levels.

93/21 **NURSING AND MIDWIFERY SAFER STAFFING**

AD presented a detailed report capturing the period January 2021 to June 2021 on nursing and midwifery staffing capacity and compliance and measures taken to address risk. During this period two reviews have been undertaken across the four divisional areas. Key points to note:-

- The current reality, in the context of the ongoing pandemic response and the recovery agenda.
- Nursing and Midwifery workforce recruitment and retention continues to be a challenge; however, the Trust is being proactive and innovative in terms of recruitment solutions.
- The continued focused leadership to support this agenda.
- The actual and planned Care Hours Per Patient Day (CHPPD) position, in particular the gap in the Registered Nurse (RN) staffing group.
- The impact upon patient experience and the quality agenda if the Trust fails to provide safe staffing numbers across all clinical areas.
- The current compliance against the Developing Workforce Safeguards (2018) guidance and action plan.

KH commented on the high sickness absence figures across registered nurses and support worker groups. KH noted the wrap around support for colleagues and was pleased to read about positive feedback whilst colleagues are working under extreme levels of pressure.

OUTCOME: The Committee **NOTED** the report and was **ASSURED** by the processes to monitor and manage nurse and midwifery staffing levels.

94/21 **DEVELOPING WORKFORCE SAFEGUARDS REPORT**

AD presented a report that outlined a summary of the Developing Workforce Safeguards (2018) and provides an assessment and action plan to ensure compliance against the 14 key recommendations. The scope of this assessment includes Nursing, Midwifery and Medical workforce groups. The Committee noted a further piece of work is to be carried out in relation to Allied Health Professionals.

- Of the 14 recommendations within the Developing workforce safeguards (2018) document the Trust is compliant with 8 recommendations, and partially compliant with 6 recommendations.
- Effective workforce planning has a positive impact on quality of care and patient, service user and staff experience, while ensuring financial resources are used efficiently.
- Accurate plans will help predict the numbers of healthcare workers required to meet future demand and supply and help with improvements in safe and effective care delivery.

KH requested an annual report is presented to the Committee in February/March 2022 followed by a 6-month update in order to measure progress. This report will be submitted to Board of Directors as an appendix to the safer staffing report.

OUTCOME: The Committee **NOTED** the assessment and **APPROVED** the action plan.

95/21 **NURSING WORKFORCE PROGRAMME**

AD presented the Nursing Workforce Programme update which outlined progress of the strategic initiatives to established safe and effective nurse and midwifery staffing. The report provided a summary of the key workstreams.

- New Data Collection for Hard Truths Process
- New Process for Approval of Changes to Workforce Models
- Use of Business Intelligence Data to inform recruitment
- Monitoring of Roster Data coupled with Nurse Sensitive Indicators to Identify 'Worry Wards'
- Successful International Recruitment Campaign
- Successful Recruitment of Newly Qualified RNs
- Ongoing Recruitment to Apprentice Nursing Associate programme
- Ongoing Recruitment to Apprentice RN programme
- EELE and CPEP programmes
- CPD Funding: *Key Risk due to lack of availability of courses and inability to release staff*
- HCSW Recruitment Programme
- HR support for Retention and Resilience for Surge Capacity Requirements
- E-Rostering

The Committee thanked AD for a comprehensive report and welcomed an update in 6 months.

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

96/21 **MEDICAL WORKFORCE PROGRAMME**

This item was deferred to the next meeting.

97/21 **PROGRESS UPDATE ON WORKFORCE STRATEGIES**

Recruitment Strategy

JR presented a progress update on the 3 year plan ending March 2022. The plan comprises 7 priorities. The response focuses around 5 core components; marketing, new starter experience and retention, talent management, training and development and policies, processes and reporting. An action plan underpinned the strategy with the majority of actions now complete. JR was delighted to report the recruitment microsite was launched earlier today, other progress and achievements include:-

- Creation of a brand that demonstrates one culture of care
- A collaborative approach to nursing recruitment
- Corporate induction focusing on Trust values
- Apprenticeships to feed into clinical posts
- Clear structure to develop colleagues
- Silver status in Armed Forces Covenant
- New colleagues automatically added to Flexible Workforce Bank (can choose to opt out)
- Better rates of pay with agencies

Consultation of a new strategy to commence October 2021 with publication in March 2022. The strategy will incorporate learning particularly from the pandemic and our approach to a flexible, diverse workforce. HS said she looks forward to being involved from a staff side perspective.

KH congratulated the team on their achievements and looked forward to seeing the new strategy.

The Committee noted Liam Whitehead, Employability Manager will be invited to the next meeting to talk about the widening participation programme.

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

98/21 **'ENHANCE' - OUR PROPOSED INCLUSIVE TALENT MANAGEMENT PROGRAMME**

NH introduced a proposed model 'Enhance', an all-inclusive integrated approach that will identify everyone's talent. Overall, the programme will support colleague's employee experience wellbeing and development, support productivity, patient experience and organisational improvements. NH highlighted in particular the advantage of being able to easily identify colleagues who are ready to support projects or areas in need of additional resource. KH agreed this is an excellent piece of work with great potential. The full presentation would be shared with the Committee.

The Committee noted that NHSE/I are in the pipeline of recommending CHFT as a talent management model.

OUTCOME: The Committee **SUPPORTED** the proposal.

99/21 **WORKFORCE COMMITTEE WORKPLAN**

The workplan was received and reviewed.

100/21 **ANY OTHER BUSINESS**

No other business was discussed.

101/21 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

RTW/Sickness absence levels
Positive progress on WRES/WDES
Nursing Workforce
BAF increase score
Recruitment Strategy
Enhance

102/21 **DATE AND TIME OF NEXT MEETING:**

8 November 2021, 10.30am – 12.30pm Deep Dive

Calderdale and Huddersfield NHS Charity

Minutes of the Charitable Funds Committee meeting held on Monday 23 August 2021, 9.00am – 10.30am via Microsoft Teams

PRESENT

Gary Boothby (GB)	Director of Finance
David Birkenhead (DB)	Medical Director
Ellen Armistead (EA)	Director of Nursing/Deputy Chief Executive
Richard Hopkin (RH)	Acting Chair/Non-Executive Director
Adele Roach (AR)	BAME Representative
Kirsty Archer (KA)	Deputy Director of Finance

IN ATTENDANCE

Emma Kovaleski (EK)	Fundraising Manager/Ops Sub Committee Rep
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Zoe Quarmby (ZQ)	ADF Financial Control
Clare Partridge (CP)	KPMG

1. DECLARATION OF INDEPENDENCE

At the beginning of the meeting the Charitable Funds Committee members made their Declaration of Independence.

2. APOLOGIES FOR ABSENCE

Apologies were received from Philip Lewer, Peter Wilkinson and Lyn Walsh.

3. MINUTES OF MEETING HELD ON 24 MAY 2021

The minutes of the meeting held on 24 May 2021 were approved as an accurate record.

4. ACTION LOG AND MATTERS ARISING

EK gave an update on the action log and this was NOTED.
CH clarified that Action 24.05.21-10 should be closed rather than showing as on the agenda as it referred to the previous meeting's bids.
RH would like all Due Dates to be shown for the next meeting.

ACTION: EK to confirm dates on Action Log for next meeting. **23.08.21 – 1**.

5. RISK REGISTER - REVIEW

EK presented the Risk Register and its contents were NOTED. This is a live document which is reviewed at each meeting and then updated if necessary.
RH asked that, moving forward, the Risk Matrix be amended slightly and attached to the Risk Register.

EK mentioned the possibility of including a risk around Gift Aid and claiming it in error and also RH mentioned the possibility of including one around Donor Vetting; EK would investigate further..

ACTION: EK to attach Risk Matrix to the Risk Register from now on. **23.08.21 – 2**.
ACTION: EK to look at including risks for Gift Aid and Donor Vetting.**23.08.21 – 3**.

6. DRAFT AUDIT HIGHLIGHTS MEMORANDUM 2021, DRAFT LETTER OF REPRESENTATION and DRAFT REPORT & ACCOUNTS 2020/21
GB gave a brief summary of the Report & Accounts 2020/21 and thanked EK and the team for 'bringing the Report to life'.
CP is happy for the Committee to approve these accounts for sign off and confirms a clean audit opinion. There was a small discussion around the Reserves policy and RH asked that we look at the presentation of the table in Note 18.
The Committee was happy to approve the Report & Accounts and CP agreed to wait for PL to sign when he returns, which will enable KPMG to complete its file documentation.

ACTION: CH/ZQ/EK to arrange for all documentation to be completed and signed off in due course. **23.08.21 – 4**.

7. TERMS OF REFERENCE – ANNUAL REVIEW
GB presented this paper on behalf of the Chair. The contents were reviewed and it was agreed that no amendments were necessary.

8. INCOME, EXPENDITURE and KPI UPDATE
EK presented this and its contents were NOTED. Updates were also given around delays re recruitment and the Imagination Appeal.

9. Q1 GENERAL PURPOSE FUNDING BIDS TO REVIEW
Bid 8 – Clinical Psychologists' resources – approved.
Bid 9 – Bereavement Support Service – approved in principle but needs to go to CISG first to ascertain if this is a recurrent model that the Trust would want to fund. If it is, then the Charity will fund for the first 12 months, with no commitment beyond that point. In the meantime, the recruitment process can begin.
Bid 12 – Training mannequins – approved subject to a check that an alternative budget does not exist.
Bid 13 – T-shirts for Patient Experience volunteers – approved.

ACTION: EK to liaise with G Sykes and J Wood re above actions and feedback to all the bidders. **23.08.21 – 5**.

10. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 17 JUNE 2021
The paper is for information only and its contents were NOTED.

11. ANY OTHER BUSINESS
EK gave an update on the CRM situation and the Rainbow Child Development Unit move to Elland, with possible funding opportunities.

AR asked about possible funding for another BAME position and EK suggested that she speak to the Inclusion & OD Manager, Paula Gladwell, in the first instance to do a scoping exercise around our networks and then, after that, put in a funding application if it was still needed.

DATE AND TIME OF NEXT MEETING:
Monday, 22 November 2021, 9 – 10.30am, via Microsoft Teams

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

AMENDED MINUTES

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

Apologies: None

Minutes of the Last Meeting

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

Donation Activity

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

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

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

Missed Opportunities and Action Taken

No missed opportunities.

Legislation Change

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

Donor Recognition Funding and Finance

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

Promotional Activity/Organ Donation Week

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

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

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

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

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

Feedback to Trust Board

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

Policies and Guidelines

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

Review of Governance Structure/ Terms of Reference

Nothing discussed.

YODELS

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

Yorkshire Organ Donation Committee – Role as Chair

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

1. To try and improve information and ideas across each Organ Donation Committee. There are currently no formal networks between committees, but Malcolm hopes to help facilitate the sharing of best practice across them. He suggested arranging a regional meeting of committee Chairs.
2. Malcolm has concerns regarding communication flows between Trust Organ Donation Committees and NHSBT Centre. He has asked that the Centre give early notice of marketing plans, so that the committees can make sure their own efforts are co-ordinated with those plans.

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

Any Other Business

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

Date and Time of Next Meeting

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

19 January, 2021

ORGAN DONATION ENGAGEMENT GROUP MEETING
WEDNESDAY 7 JULY, 2021
VIA TEAMS

AMENDED MINUTES

Present: Paul Knight, Clinical Lead, Organ Donation
Jayne Greenhalgh, Specialist nurse, Organ Donation
Sarah Whittingham, Nursing Line Manager, Organ Donation
Gary Boothby, Director of Finance
Jenny Taylor, Finance
Nicki Schofield, Staff Nurse, ICU
Caroline Winkley, Specialist Nurse, Gastroenterology
Karen Piotr, Ambassador
Annette Bell, Governor
Rebecca Johnstone, Admin Team Leader, Operating Services and Critical Care

Apologies: Suzanne Thompson, Matron
Shelley Bilston, Marketing and Campaigns Manager, NHS Blood and Transplant

Minutes of the Last Meeting

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

Matters Arising

Dr Knight will work his way through these during the meeting.

Donation Activity

Jayne Greenhalgh talked us through the slides of the Potential Donor Audit (copy of slides attached.)

Dr Knight stated that it must seem to everyone that we make so many referrals and many are not meeting the criteria. Dr Knight explained that this is deliberate so that potential donors are not missed.

Recent Missed Referral – Learning Points and Actions

Jayne Greenhalgh reported that unfortunately, approximately four week ago, we had a missed referral at CRH. The patient had an out of hospital cardiac arrest and the family were struggling with futility and were not ready to be approached. The following day it became apparent the family were at the stage where they understood that the patient was reaching end of life. At this late stage a referral was not made. Dr Knight and Jayne spoke to the clinicians involved regarding speaking to the SNOD involved early. Dr Knight has sent a summary to doctors and nurses on ICU hoping to avoid this in future.

There was another episode where a referral was made quite late and all the organ donation teams were busy at the time when the family were waiting to be spoken to. Dr Knight reported that the team on the ground did the best they could with one consultant delivering the bad news and the other moving onto establish next steps including bringing up the subject of organ donation. The team on the ground did the best that they could when they were faced with having a conversation

without the SNOD available, but this would have been avoidable had the referral been made earlier. We had a former CLOD acting in the role of SNOD. This will be flagged up in the next report.

Dr Knight reported that in order to enable successful heart donation, we need a timely echo, which can be difficult to arrange at weekends. He has drawn this to the attention of his colleagues to try and make sure that if echos are likely to be needed they might be requested within the working hours.

There is work going on behind the scenes to see if we can obtain echoes for these patients. Sarah Whittingham reported that Leeds are working on this as they have had the same problem. CLODs have a meeting planned in Leeds about setting up a weekend rota. Once this is set up, they will be in touch with us to see how we can move forward. If we are successful in setting up a regional rota, there is a echocardiography technician in Airedale who has already said he would like to be part of it. Hopefully this is something we can get off the ground for West Yorkshire.

Dr Knight welcomed the news that an out of hours echo service might be available for these patients, but mentioned that there are many more patients in the Trust that would benefit from a weekend Echo service. Dr Knight has been in contact with our echo department and they assure him that a copy of our requirements is in the department. We are fortunate that we now have an updated server where it is easy to look at moving images, so it should be less of a problem than in the past.

Donor Recognition Funding and Finance – Plans for Use of Donor Recognition Funding

Jenny Taylor reported that we have just over £14,000 available to spend from last year. We do not yet have any information about this year's allocation. Dr Knight has not received any suggestions as to how to use this money, though he spoke to theatre and ICU staff and one idea put forward is to have names printed on hats for theatre staff. Dr Knight will liaise with Matron and Band 7's about this idea, though Infection Control will have to be included. Jenny Taylor will put this on Any Other Business for the next Critical Care DMT and Operating Services DMT. In the meantime, if anyone has any more ideas, please contact Jenny.

Karen Piotr suggested vinyl wrapping on glass balustrades. Karen will send images to Dr Knight and Jayne Greenhalgh.

Dr Knight stated that the Organ Donation Corner at HRI is looking amazing. He suggested the chairs in this area being covered pink. He did state we have to make sure the money given to the Trust for organ donation is used for education as well as promotion.

Dr Knight reported that unveiling of Jovial Man will take place on Tuesday 27 July at 12 noon. Jayne Greenhalgh reported that the donor family do not feel that they could travel up to Huddersfield for this at the moment, but they do not want us to delay any further. Unfortunately, we are unable to do much due to Covid restrictions, so this will just be a five minute unveiling. Jayne will put pink ribbon around the sculpture and will ask Comms to attend. Gary Boothby suggested also asking the Huddersfield Examiner or Halifax Courier to attend the unveiling.

Promotional Activity

Karen Piotr reported that there is a community investment scheme in Bradford and that Organ Donation Week coincides with Fresher's Week. Jayne Greenhalgh asked for any ideas for promotion, but it was agreed that manning a stand is not appropriate at the moment and is not the

best use of time. Karen Piotr asked whether we could light up the Piece Hall or Wainhouse Tower and maybe the team could put feelers out regarding this. Caroline Winkley has approached the University to light up for Hepatitis Day and she will share the contact. Castle Hill have refused her request due to the cost. Huddersfield Town Hall has not yet responded.

Dr Knight asked regarding the donation we were going to send to support the Transplant Games in Leeds. Jenny Taylor stated that this donation was made, but the Games were cancelled this year due to Covid. The Games have been rescheduled for 28 – 31 July, 2022 and Jenny was contacted by the organisers to ask whether it was OK to keep the money, to which she agreed.

Karen Piotr reported that a donor walk is taking place on Saturday 7 August and a cycling event on Sunday 8 August.

Operational Matters

Dr Knight reported that there is a national call for comment on the existing donor optimisation bundle. He also reported that Covid has not really gone and there is still an uncomfortable amount of it on ICU.

Policies and Guidelines

Dr Knight reported that his intention, after Covid, is to develop better guidance on individual donor management along the lines of any new national guidance that might come out.

Review of Governance Structure

Dr Knight stated that reporting is in a permanent state of flux and asked whether we are reporting via Philip Lewer or the Clinical Outcomes Group. He reported that, in his last e-mail, Philip said he was reporting directly to Board. Gary Boothby stated that Philip feeds back after these meetings and this is minuted in the Trust Board minutes. Gary also stated that Philip's feedback is usually very positive.

Educational Activity Including YODELS

Jayne Greenhalgh stated that she has been working closely with Mahmud Nawaz, who sits on the board at Mid Yorks. Mahmud is from a donor family and is an ambassador. He is trying to get into GP education sessions, which Paul Knight and Jayne will also try to attend. Jayne reported that Mahmud is doing a really good job and is very clued up on the process.

Jayne and Paul are doing a yearly afternoon of training with all anaesthetic core trainees in the Trust and this has been really positive.

Jayne reported that the YODELS tour has now been off for 18 months. We are joining forces with Pinderfields and Bradford, but everything is still on hold. There are still no plans to restart, but hopefully this will happen next year.

Jayne reported that the Yorkshire Organ Donation Team are holding an afternoon at the West Yorkshire Police Station, where all coroner's officers will attend. There have been a couple of occasions in our Trust where families of patients who have been referred to the Coroner have had the subject of organ donation brought up by the Coroners officers. In this instance, we need to get

the message across to Coroners teams that they should not be bringing up organ donation with families as it prevents the structured collaborative approach that works.

Expectations of Link Nurses to Cascade Learning and Updates

Jayne Greenhalgh reported that, moving forward, it would be good for us to speak to new staff. Jayne is putting together an information package for new starters. The plan is for all Link Nurses to attend the virtual study days.

Changes to Staff Letters Following Donation

Jayne Greenhalgh reported that, until now, we have written to all staff involved in an organ donation. However, it has been brought to our attention that occasionally some members of staff are missed. It has been decided to send the letter to the lead nurses on ICU and they will cascade this to the staff. If anyone would like a copy of a letter for their revalidation, Jayne will be happy to provide one. Jayne has spoken to senior nurses on both ICUs and they will cascade these changes to staff.

Any Other Business

Sarah Whittingham gave a huge thank you to everyone for those phenominal figures, which is truly fantastic. Also thanks to the donor families who made the decisions. Sarah also thanked Paul and Jayne for being so proactive.

Annette Bell congratulated everyone from the governors and passed on their best wishes for continued success.

This is Annette's last Organ Donation Group meeting as she is stepping down from being a governor. Dr Knight thanked her for her service and wished her well for the future.

Dates and Times of Next Year's Meetings

Wednesday 5 January, 2022, 10.30 am via Teams.
Wednesday 6 July, 2022, 10.30 am via Teams.