Public Board of Directors - Items for Board Assurance - 7 July 2022

Organiser Amber Fox

Documents for Review

1. Review of Board Sub-Committee Annual Reports 2021/22 - In the Review Room

a) Workforce Committee

b) Finance and Performance Committee

c) Quality Committee

Date of Meeting:	**7 July 2022**
Meeting:	**Board of Directors**
Title of report:	**Workforce Committee Annual Report 2021/2022**
Author:	**Tracy Rushworth, Workforce Committee Secretary** **Jason Eddleston, Deputy Director of Workforce and Organisational Development**
Sponsor:	**Karen Heaton, Non-Executive Director/Workforce Committee Chair**
Previous Forums:	**Workforce Committee 6 June 2022**

Actions Requested

- To note

Purpose of the Report

The Workforce Committee annual report for 2021/2022 details:-

- The role of the Committee, membership and attendance between 1 April 2021 and 31 March 2022 and the terms of reference
- The activities of the Committee between 1 April 2021 and 31 March 2022
- A self-assessment completed by core Committee members of the effectiveness of the Committee.

Key Points to Note

This Annual Report is presented for information and assurance.

Recommendation

The Board of Directors is asked to note the content of the report.

WORKFORCE COMMITTEE ANNUAL REPORT 2021/2022

This Workforce Committee annual report for 2021/2022 details:-

- The role of the Committee, membership and attendance between 1 April 2021 and 31 March 2022 and the terms of reference
- The activities of the Committee between 1 April 2021 and 31 March 2022
- A self-assessment completed by core Committee members of the effectiveness of the Committee.

1. INTRODUCTION

1.1 Purpose of the Workforce Committee

The purpose of the Committee is to provide assurance to the Board on the quality and impact of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. This includes but is not limited to recruitment and retention, colleague health and wellbeing, learning and development, colleague engagement, organisational development, leadership, workforce spend and workforce planning.

The Committee oversees that there is continuous and measurable improvement in workforce activities through review of key workforce metrics in order to support the delivery of workforce performance targets.

The Committee receives assurance in relation to internal workforce activity from a number of annual reports prior to national publication. These reports include Freedom to Speak Up, Workforce Race Equality Standard, Workforce Disability Equality Standard and Gender Pay Gap. The Committee is responsible for reviewing and monitoring performance and improvement against the associated action plans.

1.2 Terms of Reference

The Committee has approved Terms of Reference in place.

The Terms of Reference were reviewed by the Committee in June 2021. The Committee agreed no further amendments were required and set a review date of May 2022.

1.3 Workforce Committee Membership and Attendance in 2021/2022

Between 1 April 2021 and 31 March 2022 the Committee met 7 times.

The core membership and attendance at the 7 Committee meetings is set out below:-

Name	Role	Number of meetings attended
CORE MEMBERS		
Karen Heaton	Non-Executive Director **(Chair)**	7/7
Ellen Armistead	Chief Nurse	5/7
Helen Barker[1]	Chief Operating Officer	0/4
David Birkenhead	Medical Director	6/7
Gary Boothby	Director of Finance	0/7
Suzanne Dunkley	Director of Workforce Organisational Development	6/7
Jason Eddleston	Deputy Director of Workforce & Organisational Development	6/7

Jo Fawcus[2]	Chief Operating Officer	0/3
Andrea McCourt	Company Secretary	5/7
Helen Senior	Staff Side	6/7
Denise Sterling	Non-Executive Director	6/7

[1] Member until November 2021
[2] Member from November 2021

2. WORKFORCE COMMITTEE ACTIVITIES 2021/2022

The activities in 2021/2022 of the Committee are set out below.

2.1 Covid Pandemic Response

On 6 December 2021 the Committee received a presentation describing the 2022 colleague wellbeing offer. The approach endorsed the existing offer recognising colleagues are experiencing mental/physical fatigue and challenges such as personal and workplace bereavement. The pandemic has highlighted complex mental health issues for many colleagues. Feedback from colleagues identified that a quick route to help and advice is needed. There are two clear access points for colleagues to secure assistance/advice – the Listening Ear service and CareFirst, the employee assistance programme. Introduction of a leadership wellbeing programme will equip managers with the right skills and capabilities to support their own wellbeing and that of those around them

In May 2021 the Committee noted Richard Hopkin, Non-Executive Director had been appointed as the Trust's Wellbeing Guardian.

2.2 CHFT Workforce Strategy

In March 2021 the Committee received an update on a review of the Trust's people strategy, The Cupboard, and progress in taking action on NHS provider specific NHS People Plan activities. A CHFT people strategy refresh has been impacted by focus on pandemic activity, however, key elements of The Cupboard continue to be developed and updates provided to the Committee.

2.2.1 Apprenticeship Strategy

The Committee received an update on 9 August 2021. The pandemic had a significant impact on new apprentice starts, timely completions and levy utilisation however the Committee was delighted the team achieved an overall effectiveness of 'Good' in the July 2021 Ofsted inspection of the Trust's in-house delivery of Healthcare Support Worker level 2 apprenticeship. Four of the 5 elements were rated as 'Good' with the fifth, Behaviour and Attitudes rated 'Outstanding'.

2.2.2 Equality, Diversity and Inclusion Strategy

A progress update was presented to the Committee on 9 August 2021. The highlights included a significant growth in the number of networks, appointment of a BAME Community Engagement Advisor and establishment of a Widening Participation team. Tailored wellbeing packages to support individual colleagues were put in place along with support for colleagues affected by the Covid pandemic in India. Leadership development and talent succession focusses on inclusive, equality discussions with One Culture of Care and health and wellbeing at the heart of the conversation.

On 10 May 2021 a paper was presented to the Committee that set out equality and diversity profiles of applicants. The data showed a lower percentage of applications and appointments across a wide range of protected characteristic categories. Having examined the recruitment

data, the Committee requested an action plan should be developed. On 9 August 2021 the Committee received an analysis of recruitment activity to demonstrate equality, diversity and inclusion data against the context of the local population along with details of activities and actions to improve and strengthen inclusive recruitment.

2.2.3 Recruitment Strategy

On 30 September 2021 a progress update was presented to the Committee on the 3-year plan ending March 2022. The plan comprised 7 priorities. The response focused 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. The recruitment microsite was launched on 30 September 2021. Consultation of a new Recruitment Strategy began October 2021 for publication in March 2022. The strategy will incorporate learning particularly from the pandemic and our approach to a flexible, diverse workforce.

2.2.4 Leadership Development

On 9 August 2021 the outcome of a review of the Leadership Development platform was shared with the Committee. 1301 colleagues had enrolled onto the programme. The pandemic impact on workload hugely affected colleagues' opportunity for development. Proposed enhancements to complement the current digital learning were detailed. A blended approach will be introduced to include action learning groups, workshops, reflective practice, coaching and mentoring.

2.2.5 Enhance

On 30 September 2021 a proposed model 'Enhance' was introduced to the Committee. The programme is an all-inclusive integrated talent management 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.

2.3 Board Assurance Framework (BAF)

The Committee regularly reviews the BAF to ensure that all risks relating to workforce are identified and managed to mitigate the risks. Four workforce risks are noted:

- Medical Staffing
- Nurse Staffing
- Recruitment/Retention inclusive leadership
- Colleague Engagement

In May 2021 the Committee agreed to receive a deep dive into one risk at each of its meetings.

2.4 Improving People Practices

The Committee had received papers in November 2019 and December 2020 in relation to the request from NHSE/I for organisations to review their disciplinary policy and associated procedures. In May 2021 the Committee received details of the assessment of the Trust's Disciplinary Policy and Procedures when compared to that of Imperial College Healthcare NHS Trust. 31 differences were identified. Each difference was fully assessed, and a decision reached to either adopt the Imperial College Healthcare NHS Trust's position to enhance current practice or retain the Trust's current position. One Culture of Care is demonstrated in each of CHFT's employment policies.

2.5 Gender Pay Gap (GPG)

On 10 May 2021 the Committee received the GPG data for the year ending 31 March 2020, and preliminary data and analysis for the year ending 31 March 2021. The Committee noted the improved position in the last 12 months. A 5-year Equality, Diversity and Inclusion Plan has been developed which will include a commitment to identifying and taking steps to further reduce the GPG. To enable this to happen CHFT will continue to work with trade unions, equality groups, employee support networks and other stakeholders.

2.6 Return to Work (RTW) Interviews

On 10 May 2021 the Committee was updated on the compliance position for RTW interviews and the steps being taken to improve compliance. Examination of the data revealed a significant lag in reporting. A refreshed action plan has been developed which will support directorate teams to have more oversight and accountability for their workforce metrics.

2.7 Business Better than Usual (BBTU)

In June 2021 the Committee received its first overview of the learning during the pandemic. Areas were identified by colleagues, partner organisations and public feedback of how new ways of working implemented during the pandemic have brought benefit and should continue and be amplified moving forward. Over the last 15 months a programme of transformation had been developed. Progress reports were made against the specific themes identified and reported at Board sub-committees.

2.8 Freedom to Speak Up (FTSU)

In June 2021 the Committee received the FTSU annual report for the period 30 June 2020 to 28 May 2021. Key themes have not changed over the last three years. Increase in reported concerns in 2020 is likely to be attributed to the pandemic. The report showed a significant number of anonymous concerns. A new FTSU Guardian was appointed in September 2021. In December 2021 a FTSU mid-year review was presented to the Committee. On review of the concerns raised during Q1 and Q2 no specific common themes had been identified however the number of concerns raised anonymously is notable and suggests that colleagues might not feel safe to raise concerns confidentially or openly. Key messages of reassurance have been injected to comms and promotional materials. Four key themes and actions were produced as a result of a FTSU Board Assessment carried out in June 2021.

2.9 Pay Anomalies

Following a previous report, the Committee received a further paper on 7June 2021 that provided an update on the exercise to examine payments made to employees in the Trust that fall outside nationally agreed and locally implemented terms and conditions of employment. Further work was to be completed to determine jointly with service leads whether the existing payments are retained. Additionally, a mechanism to regularly review payments and to consider any new payments that operate outside national pay frameworks would be finalised.

2.10 Trade Union Facility Time

In June 2021 the Committee received a report that set out reporting requirements for public sector organisations in relation to paid trade union facility time and the Trust's data for the period 1 April 2020 to 31 March 2021. The Regulations require NHS Foundation Trusts to publish on public websites, in annual reports and on gov.uk the cost of paid facility time taken by employees acting as staff side representatives. The Trust introduced a Recognition and Facilities Agreement in January 2019 which sets out clear procedures on time off for trade union duties. For 2020/2021 the Trust is reporting 251.76 fte days capturing 24 colleagues with an estimated cost of £53,338.00. According to NHS Employers the unofficial benchmark set by Government is 0.06%

of the paybill. The Trust's figures since reporting began in 2018/2019 have been 0.02% each year, below the benchmark figure.

2.11 2020 NHS Staff Survey Action Plans

The Committee was advised in August 2021 the Board of Directors had received an update at its July 2021 meeting. The Committee noted divisional progress is monitored at performance review meetings with the Trust-wide action plan being overseen by Workforce and Organisational Development. The importance of the wellbeing agenda was noted. The updated action plans were shared with the Committee.

2.12 Revalidation and Appraisal on Non-Training Grade Medical Staff

As a result of the pandemic the appraisal process was suspended by NHSE in March 2020. The process was restarted in October 2020 using a temporary revised appraisal format, however the need to complete an appraisal was not mandated. Similarly the GMC suspended for 12 months revalidation recommendations due between March 2020 and March 2021. As such an annual report wasn't produced however a paper presented to the Committee in August 2021 outlined the Trust's management of medical appraisals.

2.13 Nursing and Midwifery Safer Staffing

On 30 September 2021 the Committee received a paper capturing the period January 2021 to June 2021 on nursing and midwifery staffing capacity and compliance and measures taken to address risk. The Committee was assured by the processes to monitor and manage nurse and midwifery staffing levels.

2.14 Developing Workforce Safeguards Report

On 30 September 2021 the Committee received a report that outlined a summary of the Developing Workforce Safeguards (2018) and provided an assessment and action plan to ensure compliance against the 14 key recommendations.

2.15 Nursing Workforce Programme Update

A report was presented to the Committee on 30 September 2021 that outlined progress of the strategic initiatives to established safe and effective nurse and midwifery staffing. The report provided a summary of the key workstreams.

2.16 Workforce Race Equality Standard (WRES)

On 30 September 2021 the Committee received the annual report. An action plan developed by the BAME Network Group outlined the successes of the last 12 months. The action plan contained more virtual interaction, more online education and awareness and our approach to One Culture of Care will support positive change. There will also be an increased level of support for colleagues across the Trust to support self-care and personal wellbeing. The action plan will be monitored by the Inclusion Advisory Group on a bi-annual basis along with regular discussion at all the Trust's Equality Groups. Progress updates would be provided to the Committee.

2.17 Workforce Disability Equality Standard (WDES)

On 30 September 2021 the Committee received the annual report. The Trust's Colleague Disability Action Group was instrumental in the development of the associated action plan. The biggest area of progress is the formation of colleague network groups with a view that more colleague involvement in these platforms creates opportunity to push forward change. Progress updates will be provided to the Committee.

2.18 Medical Workforce Programme

In November 2021 a report presented to the Committee described the current medical workforce establishment and measures being taken to address medical staffing risk.

2.19 GMC National Survey of Trainee Doctors 2021

On 8 November 2021 the Committee received the results of the 2021 GMC national survey of trainee doctors that took place between 21 April 2021 and 25 May 2021. CHFT response rate was once again 100% (highest in region for the 8th year in a row) and was the 6th highest in terms of overall satisfaction. Overall satisfaction remained at pre-pandemic level, as did clinical supervision, teamwork and educational governance.

2.20 Employability

On 8 November 2021 the Committee received a 'story so far' on the progress, partnership development and upcoming priorities for Employability. 6 clear priorities had been identified. Contracts to recruit 20 young, unemployed adults had been secured in line with the government funded programme – Kickstart. Since October 2021, 47 volunteers had re-commenced in the Trust following careful evaluation of safety compliance.

2.21 Education Committee (EC)

In December 2021 the Committee learned of the arrangements for the new EC. Terms of reference and guiding principles were shared with the Committee. The EC would meet every 2 months commencing January 2022 and provide an update report at each Committee.

2.22 2021 NHS Staff Survey

On 15 February 2022 the Committee learned the staff survey results were embargoed until early March. The high-level results were presented on screen only. The overarching response will be to work with local teams to improve colleague experience in the organisation.

2.23 Review and Monitor Key Workforce Metrics

At each of its meetings the Committee reviews the Quality and Performance (Workforce) report. The report comprises of key workforce metrics:-

- Sickness absence
- Retention and Turnover
- Essential Safety Training
- Appraisal
- Recruitment
- Bank/Agency Spend

The Committee receives a quarterly vacancy report for all staff groups. The report provides information about current vacancies, recruitment activities, updates on hotspot areas and actions taken.

During the period 1 April 2021 to 31 March 2022 the Committee undertook deep dives into the following:-

- Allied Health Professionals recruitment and vacancy position
- Maternity specific Essential Safety Training
- Estates and Ancillary sickness absence
- Administrative and Clerical roles turnover.

2.24 Hot House events

A ‘Leadership Skills Required in a Post Covid World’ themed Hot House took place on 7 June 2021. The aim of the session was to identify what skills were needed and how to enhance our existing leadership and management development programmes to enable leaders and managers to successfully lead their teams in a post-Covid environment.

Hot Houses scheduled for September 2021 and December 2021 were cancelled due to the pandemic.

The Hot House ‘The CHFT colleague journey’ scheduled for March 2022 was postponed until 29 April 2022 as notification was received that the full staff survey results would not be available until the end of March 2022 when the national survey results portal would be accessible to the public.

3. EFFECTIVENESS OF WORKFORCE COMMITTEE

On an annual basis, the Committee undertakes a self-assessment exercise to gauge its effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place, in May 2022. The results are set out in Appendix 1. The action plan will be developed, presented and agreed at a future meeting.

4. CONCLUSION

As described above, the Committee has received assurance through the course of 2021/2022 from a number of sources. The Committee confirms it has fulfilled its role to the Board during 1 April 2021 to 31 March 2022 undertaking its key functions of providing assurance that that there is continuous and measurable improvement in the development of workforce strategies, the effectiveness of workforce management in the Trust that align to One Culture of Care and ensuring workforce risks are managed appropriately.

Tracy Rushworth
Workforce Committee Secretary

Jason Eddleston
Deputy Director of Workforce and Organisational Development

June 2022

Appendix A

Workforce Committee Self-assessment form

Anyone with this link can view a summary of responses

https://forms.office.com/Pages/AnalysisPage.aspx?AnalyzerToken=w2g Copy

1. COMMITTEE FOCUS: The Committee has set itself a series of objectives it wants to achieve this year.

Strongly Agree	2
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

2. COMMITTEE FOCUS: The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.

Strongly Agree	3
Agree	2
Disagree	0
Strongly Disagree	0
Unable to answer	1

Appendix A

3. COMMITTEE FOCUS: Committee members contribute regularly across the range of issues discussed.

Strongly Agree	4
Agree	2
Disagree	0
Strongly Disagree	0
Unable to answer	0

4. COMMITTEE FOCUS: The Committee is fully aware of the key sources of assurance and the key individuals/teams responsible for risk mitigation.

Strongly Agree	2
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	1

5. COMMITTEE FOCUS: The purpose of the Committee is to provide assurance to the Board on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust.

Strongly Agree	5
Agree	1
Disagree	0
Strongly Disagree	0
Unable to Answer	0

Appendix A

6. COMMITTEE TEAM WORKING: The Committee has the right balance of experience, knowledge and skills to fulfil its role.

Strongly Agree	1
Agree	4
Disagree	1
Strongly Disagree	0
Unable to answer	0

7. COMMITTEE TEAM WORKING: The Committee has structured its agenda to cover the full range of workforce matters and priorities including Recruitment, Retention, Workforce Planning, Agency Spend, Attendance Management, Colleague Engagement, Colleague Health and Wellbeing, Organisation Development and Leadership. This list is not exhaustive.

Strongly Agree	3
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	0

8. COMMITTEE TEAM WORKING: The Committee ensures that the relevant director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.

Strongly Agree	1
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	1

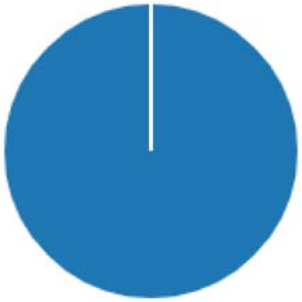
Appendix A

9. COMMITTEE TEAM WORKING: The Committee is fully briefed via the assurance framework (including the Board Assurance Framework) on key risks, assurances and gaps in control in a timely fashion eradicating the potential for 'surprises'.

Strongly Agree	2
Agree	3
Disagree	1
Strongly Disagree	0
Unable to answer	0

10. COMMITTEE TEAM WORKING: I feel sufficiently comfortable within the Committee environment to be able to express my views, doubts and opinions.

Strongly Agree	6
Agree	0
Disagree	0
Strongly Disagree	0
Unable to answer	0



11. COMMITTEE TEAM WORKING: Members hold their assurance providers to account for late or missing assurances.

Strongly Agree	1
Agree	3
Disagree	1
Strongly Disagree	0
Unable to answer	1

Appendix A

12. COMMITTEE TEAM WORKING: When a decision has been made or action agreed, I feel confident that it will be implemented as agreed and in line with the timescale set down.

Strongly Agree	4
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	1

13. COMMITTEE EFFECTIVENESS: The quality of Committee papers received allows me to perform my role effectively.

Strongly Agree	2
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

14. COMMITTEE EFFECTIVENESS: Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.

Strongly Agree	3
Agree	2
Disagree	1
Strongly Disagree	0
Unable to answer	0

Appendix A

15. COMMITTEE EFFECTIVENESS: Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.

Strongly Agree	3
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	0

16. COMMITTEE EFFECTIVENESS: Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.

Strongly Agree	2
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

17. COMMITTEE EFFECTIVENESS: At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.

Strongly Agree	2
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

Appendix A

18. COMMITTEE EFFECTIVENESS: The Board of Directors challenges and understands the reporting from this Committee.

Strongly Agree	1
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	2

19. COMMITTEE EFFECTIVENESS: There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.

Strongly Agree	5
Agree	0
Disagree	0
Strongly Disagree	0
Unable to Answer	1

20. COMMITTEE ENGAGEMENT: The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.

Strongly Agree	1
Agree	4
Disagree	1
Strongly Disagree	0
Unable to Answer	0

Appendix A

21. COMMITTEE ENGAGEMENT: The Committee is clear about the complementary relationship it has with other Board committees.

Strongly Agree	3
Agree	2
Disagree	1
Strongly Disagree	0
Unable to Answer	0

22. COMMITTEE ENGAGEMENT: I can provide two examples of where we, as a Committee, have focused on improvements to the system of internal control as a result of assurance gaps identified.

Strongly Agree	2
Agree	3
Disagree	1
Strongly Disagree	0
Unable to Answer	0

23. COMMITTEE LEADERSHIP: The Committee Chair has a positive impact on the performance of the Committee.

Strongly Agree	3
Agree	3
Disagree	0
Strongly Disagree	0
Unable to Answer	0

Appendix A

24. COMMITTEE LEADERSHIP: Committee meetings are chaired effectively and with clarity of purpose and outcome.

Strongly Agree	5
Agree	1
Disagree	0
Strongly Disagree	0
Unable to Answer	0

25. COMMITTEE LEADERSHIP: The Committee Chair is visible within the organisation and is considered approachable.

Strongly Agree	2
Agree	4
Disagree	0
Strongly Disagree	0
Unable to Answer	0

26. COMMITTEE LEADERSHIP: The Committee Chair allows debate to flow freely and does not assert his/her own views too strongly.

Strongly Agree	3
Agree	3
Disagree	0
Strongly disagree	0
Unable to Answer	0

Appendix A

27. COMMITTEE LEADERSHIP: The Committee Chair provides clear and concise information to the Board on the activities of the Committee and the implications of all identified gaps in assurance/control.

Strongly Agree	1
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	2

28. Please provide any further comments here for any of the questions above

2

Responses

Latest Responses

Calderdale and Huddersfield NHS Foundation Trust

Date of Meeting:	Thursday 7 July 2022
Meeting:	Board of Directors – Items for Board Assurance
Title:	Finance and Performance Committee Annual Review 2021/22
Author:	Kirsty Archer, Deputy Director of Finance
Sponsoring Director:	Gary Boothby, Director of Finance
Previous Forums:	Finance and Performance Committee 3 May 2022

Purpose of the Report

Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2021/22 setting out how it has met its Terms of Reference and key priorities.

Key Points to Note

The Committee has carried out its business in the last 12 months in accordance with the terms of reference and the meetings have been well attended. A good balance has been achieved between financial and operational matters and there has been valuable input from other executives, clinicians and managers outside the Committee. In year regular updates have been provided on how the Trust has continued to respond to the pandemic including impact on performance and review of activity recovery plans, alongside financial implications. A self-assessment has been completed in year and an action plan formed in response to this feedback.

EQIA – Equality Impact Assessment

Individual decisions made by the committee during the course of the year will have been required to undergo a QIA and EQIA as appropriate

Recommendation

The Board is asked to **NOTE** the attached summary.

Finance and Performance Committee
Annual Review 2021/22

1. Background

Good practice states that the performance Board sub-committees should be reviewed annually to determine if they have been effective, and whether further development work is required. This Annual Report summarises the activities of the Trust's Finance and Performance Committee (the Committee) for the financial year 2021/22 setting out how it has met its Terms of Reference and key priorities. These were reviewed and updated in November 2021.

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

2. Finance and Financial Performance

Monthly reporting is provided to the Committee by way of a comprehensive pack of financial metrics and narrative on the year to date and forecast position against the plan for the year. This pack covers the activity, income and expenditure position including cost improvement programme (CIP), capital, cash and use of resources metric. In 2021/22 particular focus has also been given to Covid and elective recovery costs. The financial risks which form part of the overall Trust risk register are reviewed against the intelligence in this report and discussed by the Committee on a regular basis. The financial elements and other specific risks from the Board Assurance Framework are also reviewed by the Committee against the in-year performance and longer-term outlook.

In June 2021 the Committee received a refreshed version of the 'Fiscally Unique' analysis detailing the key drivers behind the Trust's underlying deficit and a report compiling the Trust's progress against the Use of Resources review caried out in 2018 by NHSI as part of the CQC Inspection. This report was requested by the Committee for a number of reasons:

- to demonstrate, in one place, progress against the actions
- to collate the latest scores where possible
- to identify further opportunities to explore and lead to further improvement on our use of resources

In November 2021 the Committee received a proposal to establish the Efficient Use of Resources Group (ERG) with a focus on Half 2 of 2021/22 and onwards into 2022/23. Regular reports followed thereafter on progress from this group.

3. Performance Delivery and Assurance

The Committee receives the monthly Integrated Performance Report which is presented to draw out key messages from the comprehensive report, highlighting particularly positive performance and areas of concern and management actions to maintain the former and address the latter.

In 2021/22 further information has also been regularly received by the Committee on the Trust's elective recovery trajectories, detailing progress to date and future forecasting. These have been presented and discussed drawing out the particular challenges and achievements in specific specialty areas.

During the course of the year the Committee has requested a number of deep dives into specific clinical specialties or areas of performance, examples include a deep dive into colleague availability in August 2021 and an update on stroke performance received in February 2022. These presentations have been made directly to the Committee by subject matter experts who were able to bring the topics to life and answer questions which was well received by committee members.

The minutes of the A&E Delivery Board are routinely received.

4. Business and Commercial Development

The Committee's prior understanding of the long-term plan set the context for the operational and financial plans ratified in year. This covered Half 2 (H2) on 21/22 received in November 2021 and the final 22/23 plans received in early April 2022.

The Committee routinely receives the Board minutes and annual reports from the Trust's commercial areas, Huddersfield Pharmacy Specials and The Health Informatics Service. In addition, minutes are received from the Commercial Investment Strategy Committee (superseded in year by the newly formed Business Case Approvals Group) and Capital Management Group detailing business case approvals, progress and expected deliverables. Minutes are also received from the Joint Liaison Committee where the relationship between the Trust and CHS, its wholly owned subsidiary is managed.

5. Treasury Management

In both August 2021 and February2022 the Committee received reports on treasury management in 2021/22, the latter also highlighted points to note in relation to the 2022/23 plans.

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

The activities undertaken through the Cash Management Committee are reported to the Committee through receipt of the minutes on a quarterly basis.

6. Procurement

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

7. Membership, Attendance and Monitoring Effectiveness

The Committee is held on a monthly basis and was quorate for 11 of the 12 meetings. A register of attendance is shown at Appendix 1.

A self-assessment questionnaire in relation to the effectiveness of the committee is carried out on an annual basis. The latest was reported to the Committee in January 2022 and the responses were positive. An action plan was agreed to address specific comments raised.

8. Summary and Recommendation

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

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

FINANCE & PERFORMANCE ATTENDANCE – 2021/22

	May M 1 Tues 1 June	June M 2 28 June	July M 3 2 Aug	Aug M 4 Tues 31 Aug	Sept M 5 4 Oct	Oct M 6 1 Nov	Nov M 7 29 Nov	Dec M 8 10 Jan 2022	Jan M 9 31 Jan	Feb M10 28 Feb	March M11 4 Apr	April M12 Tues 3 May		Self-Assessment to be presented at the April ARC
MEMBERS														Received Completed
Helen Barker	✓	Apols	✓	✓	Retired									
Jo Fawcus							✓	✓	Apols	✓	✓			
Anna Basford	Apols	✓	✓	Apols	✓	Apols	✓	✓	✓	Apols	✓	Apols		
Gary Boothby	✓	✓	✓	Apols	Apols	✓	✓	✓	✓	✓	✓			
Owen Williams	Apols	✓	✓	✓	Apols	✓	Left CHFT							
Brendan Brown								Apols	Apols	Apols	Apols			
Richard Hopkin Non-Exec (Chair)	✓	✓	✓	✓	✓	Apols	✓	✓	✓	✓	✓			
Peter Wilkinson Non-Exec (Vice-Chair)	Apols	✓	✓	✓	Apols	✓	✓	Apols	Apols	✓	Apols			
IN ATTENDANCE														
Kirsty Archer	Apols	✓	Apols	✓	✓	✓	✓	✓	✓	✓	✓			
Stuart Baron	Apols	✓	✓	Apols	Apols	Apols	Apols	✓	✓	✓	✓			
Philip Lewer	✓	Apols	✓	Apols	✓	✓	✓	✓	✓	Apols	✓			
Andrea McCourt	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Peter Keogh	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Stephen Baines	✓	Apols	✓	✓	Apols	No longer in attendance								
Robert Markless (Governor)						✓	✓	✓	✓	✓	✓			
Brian Moore (Governor)						✓	Apols	✓	✓	✓	✓			
Isaac Dziya (Deputy Governor)							✓		✓					

Date of Meeting:	Thursday 7 July 2022
Meeting:	Board of Directors – Items for Board Assurance
Title of report:	Quality Committee Annual Report 2021/2022
Author:	Michelle Augustine, Governance Administrator Denise Sterling, Non-Executive Director
Sponsor:	Denise Sterling - Non-Executive Director and Chair of Quality Committee Chair
Previous Forums:	Quality Committee

Purpose of the Report

This annual report describes the activities of the Quality Committee between April 2021 and March 2022, describing how the Committee met the duties within the terms of reference. The report includes:

- An overview of the role of the Quality Committee
- Details of membership and attendance between April 2021 and March 2022
- Information of the work of the Committee in the following areas:

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

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

Key Points to Note

This annual report is presented for information and assurance and will be shared with the Board of Directors on Thursday, 7 July 2022.

Recommendation

The Board is asked to **NOTE** the assurances in the Annual Report that the Committee met its duties for the reporting period of 2021/2022.

Quality Committee Annual Report 2021 / 2022

This Quality Committee annual report for 2021 / 2022 details:

- The role of the Quality Committee, membership and attendance between April 2021 and March 2022 and the terms of reference
- The activities of the Quality Committee between April 2021 and March 2022
- Self- assessment of the effectiveness of the committee

1. Introduction

Purpose of the Quality Committee

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

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

The Quality Committee receives assurance from a number of quality sub-groups via an annual work plan structured around the CQC domains. The work plan continued to be reviewed and updated during the year.

Terms of Reference

Following the revision to the governance structure, the terms of reference were amended in April 2021 to include the addition of the Medicines Management Committee, CQC and Compliance Group, Clinical Effectiveness and Audit Group, Clinical Ethics Group and the Medical Gases Group as sub-groups, and the removal of the Serious Incident Review Group, Medication Safety and Compliance Group, and the Cancer Board as sub-groups. Further amendments were made throughout the year, including:

- **July 2021** – to include the re-instatement of the Cancer Board as a sub-group, by receiving minutes only
- **October 2021** – to include the removal of the named public elected governor following end of tenure
- **November 2021** – to include the addition of named Chief Operating Officer to core membership
- **February 2022** – to include the removal of the role of Assistant Director for Patient Experience from core membership; the addition of Legal Services reporting into the Quality Committee, and the addition of the Associate Non-Executive Director (NED) to the core membership.

Following a detailed review by NHS England / Improvement, guidance was issued in December 2021 setting out a new approach to ensure Board oversight of important issues, by discharging the activities and responsibilities held by NEDs through existing Board Committees, rather than through individual NED roles. Changes were made to the Quality Committee Terms of Reference in February 2022 to confirm the additional areas of responsibility for the Committee in line with the national guidance. These included:

- Hip fracture, falls and dementia
- Learning from Deaths (requirement for this to be reported in the public domain)
- Palliative Care & End of Life Care
- Safeguarding (reports to Board annually)
- Resuscitation (reports to Quality Committee via Trust Patient Safety Quality Board)
- Children and Young People - the CQC Core Service Inspection Framework for Children and Young People refers to an interview with the NED in the Board with responsibility for Children and Young People, this is by a NED member of the Quality Committee
- Health & Safety - e.g., patient safety.

The current terms of reference were approved by the Board of Directors on 3 March 2022.

Quality Committee Membership and Attendance in 2021/2022

The Quality Committee met on 12 occasions between April 2021 and March 2022, and no meetings were cancelled during this time.

The membership and attendance at the Quality Committee between April 2021 and March 2022 is given below, with one member of the Council of Governors invited to attend and observe each meeting.

Role	Number of meetings attended
Non-Executive Director **(Chair)**	11 / 12
Non-Executive Director **(Vice-Chair)**	10 / 12
Associate Non-Executive Director	2 / 2
Executive Director of Nursing	11 / 12
Deputy Director of Nursing	7 / 12
Medical Director	8 / 12
Associate Director of Quality and Safety	8 / 12
Deputy Medical Director	8 / 12
Deputy Director of Workforce & Organisational Development	12 / 12
Chief Operating Officer	3 / 4
Head of Risk and Compliance	7 / 8
Public Elected Governor **(Observer)**	11 / 12
Staff Elected Governor **(Observer)**	2 / 5
Clinical Director of Pharmacy	9 / 12
Governance Administrator	11 / 12

- The role of the Associate Non-Executive Director began in February 2022
- The Chief Operating Officer began attendance in December 2021;
- The role of Head of Risk and Compliance was vacant for the duration of four meetings
- The role of Assistant Director of Quality and Safety was vacant for the duration of two meetings.
- From November 2021, two governors (Public elected and Staff Elected) were allocated to attend this Committee.

2. Quality Committee Activities 2021 / 2022

The principal activities of the Quality Committee during April 2021 and March 2022 are detailed below within the areas of quality improvement, risk, patient safety, audit and assurance and quality and safety reporting from sub-groups. There was also ongoing focus on quality and safety relating to the pandemic and post-pandemic response.

2.1 Quality Improvement

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

- **Health and Wellbeing Recovery Strategy** – the Committee received an update on the development of the wellbeing strategy and next steps to 'recovery' and recommendations on future plans.

- **John Smith Stadium Community Vaccination Centre** – the Committee received assurance in April 2021 on the governance arrangements in place for the COVID-19 vaccination programmes at the John Smith Stadium Vaccination Centre in Kirklees and the CHFT hospital hub vaccination programme for health and social care workers. The Committee approved oversight of the vaccination programmes and the Operational Policy. A further update was provided in July 2021 on progress and next steps, followed by a final quality assurance paper in September 2021.

- **Medical Examiner Update –** the Committee received the first update in April 2021 on the service which commenced in December 2020, providing independent scrutiny of all deaths in the organisation. Process, activity and benefits of the service were provided, as well as any concerns and areas for improvement. A further update was received in November 2021, with subsequent updates provided on a six-monthly basis.

- **Getting It Right First Time** (GIRFT) – the Committee received an update in April 2021 on the Trust's progress of the national GIRFT programme, which was suspended for the duration of the pandemic. There were three virtual peer review visits and 13 action plan review meetings, which are part of the governance process to assess progress against agreed actions. Further updates were provided in November 2021 and February 2022.

- **Impact Assessment Process for reconfiguration** – a refresh of the quality impact assessment (QIA) and equality impact assessments (EqIA) process of the clinical model developed to deliver the reconfiguration of hospital services was received in May 2021, providing assurance of ongoing work.

- **Maternity Reports** – **Following the Ockenden Review, m**onthly updates are provided by to the Committee by maternity services. An overview of the requirements for Year 4 of the Maternity Incentive Scheme was received in September 2021, describing the 10 safety actions which the Trust need to achieve by 30 June 2022.

- **Complaints** – the annual report was received in June 2021, outlining areas of focus during the year and changes introduced to help deliver sustainable improvements to complaints handling within the Trust.

- **Experience, Participation and Equality Report** – the annual report on Patients, Carers and the Public: Experiences, Participation and Equalities was provided in June 2021, as well as a Friends and Family Test (FFT) update, and notification that the Patient Experience and Caring Group will be restarting following the pandemic.

- **Learning from Deaths** – the Committee received the annual report in June 2021, and quarterly reports in August 2021, October 2021 and February 2022.

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

- **Business Better than Usual** – Quarterly reports were received on progress of the work programme and the updated self-assessment against each of the 12 themes.

- **Hospital-Onset COVID-19 Infections Report** - an overview of the governance arrangements for review of harm associated with hospital onset COVID infections (HOCI) was received by the Committee in August 2021. The report highlighted the Trust's response to HOCI cases and the learning in relation to them.

- **Safeguarding** – six-month and annual reports were received from the Safeguarding team with an overview of national and local context of safeguarding, assurance on key performance activity and information on how statutory responsibilities are met, and any significant issues of risks and how they are mitigated.

- **Review of organisation performance against 36 hour admission to surgery target within best practice tariff** – An assurance update was provided in October 2021 stating that the surgical division are reviewing the current performance, developing a divisional action plan to improve performance and reducing the Trust's hip fracture related mortality rate.

- **Medicines reconciliation** – an update was provided in December 2021 on the reality, result and response to medicines reconciliation, which was described as every patient having their medicines reconciled by a member of the pharmacy team, ideally within 24 hours of admission. Further updates on progress will be provided on a six-monthly basis.

- **Children's Experience** – an update was provided in January 2022 on the CQC-commissioned inpatient children's experience report. Updates will be submitted to the Committee on a quarterly basis, as well as the improvement plan which will be monitored by the Committee. The plan returned to the Committee in March 2022, with subsequent reports to be submitted showing progress made.

- **National Standards for Cleaning Report** – a report was provided in February 2022 on the requirements to comply to the standards which are mandated to be completed by May 2022. The Trust is currently on schedule for completion.

- **Dementia Screening** – an update was provided in July 2021 to improve dementia screening across the Trust. A further update was provided in March 2022 on the challenges with improving dementia screen compliance, with ways to improve compliance provided.

- **SAFER Programme** - An update on the programme (**S**ee me; **A**dmission avoidance; **F**low from hospital to home; **E**arly intervention, and **R**eason to reside) was provided in August 2021, with a focus on quality improvement, service improvement and patient care.

- **Falls Collaborative** - An update was provided in March 2022 on a number of initiatives put in place to mitigate risks.

2.2 Risk and Patient Safety

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

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

- **Serious incidents** – an update on the current position of serious incidents, associated investigations and action plans was provided. It was noted that during a Clinical Commissioning Group meeting, it was acknowledged that CHFT, compared to other Trusts, are in a better place in terms of submitting reports in a timely manner and allocating serious incidents to investigators.

- **Patient Safety Specialist** – a presentation was provided in November 2021 on the patient safety specialist role, which is an NHS England/NHS Improvement mandated role for a dedicated whole time equivalent patient safety specialist, who will be fully trained in the national patient safety syllabus. This full-time role will support the Assistant Director of Quality and Safety role, alongside the medical lead and links with other colleagues. The Committee were supportive of the development of the role.

- **Central Alert System Process** – Safety alerts were a concern of the Committee and were monitored throughout the year. An update was requested and provided in February 2022 on the revised process on safety alerts coming into the organisation, disseminated, and acted upon. It was noted that since the process was implemented, some safety alerts were closed before their deadline.

2.3 Quality and Safety Reporting

- **Quality reports** – these were received on a bi-monthly basis.

- **Quality Priorities** – Updates were provided in April 2021 on the closure of quality priorities for 2020-2021. These included:

  - *Nosocomial Spread* – which became a quality account priority for 2021-2022 as 'reducing the number of hospital acquired infections including COVID-19'

  - *Medical Devices* – although this did not continue as a focused quality priority; it continues to be monitored via the Trust Patient Safety and Quality Board (PSQB), which then reports into the Quality Committee.

  - *Impact of business better than usual* – this did not continue as a quality priority for 2021-2022, however, the Quality Committee was assured that the actions and implementation of the themes will be received into the Transformation Programme Board, and as work progresses, the Committee will continue to have an interest regarding the impact on equality impact assessments (EQIA) and quality impact assessments (QIA) of any of the actions taken forward.

  - *Learning lessons to improve patient experience*

  - *Improving staff handovers to ensure they routinely refer to the psychological and emotional needs of patients, as well as their carers.*

  - *Improving resources for distressed relatives/breaking bad news relating to end-of-life care.*

Reducing the number of hospital acquired infections including COVID-19 (formally Nosocomial spread), End of Life Care and falls resulting in harm continued as quality priorities for 2021-2022 including increasing the quality of Clinical documentation across CHFT and Clinical prioritisation.

New priorities were introduced for Recognition and timely treatment of sepsis; Reduction of wating times for individuals in the Emergency Department; Nutrition and hydration for inpatient adult and paediatric patients; Reduction in the number of CHFT acquired pressure ulcers and Making complaints count.

- **Quality Account** - The Committee had delegated responsibility from the Board of Directors to approve the 2020-2021 Quality Accounts, which took place in June 2021 via an extraordinary meeting. The 2021-2022 Quality Account timeline was provided in March 2022, for final approval of the 2021-2022 Quality Accounts to take place in June 2022.

2.4 Audit and Assurance

- **Board Assurance Framework** - The Committee received updates on the risks on the Board Assurance Framework (BAF), which relate to achieving strategic objectives. The committee had oversight on a number of risks and deep dives were undertaken on the following:

  - 4/19 - Patient and Public Involvement – update received October 2021
  - 6/19 - Compliance with quality & safety standards – update received November 2021
  - 4/20 - CQC rating – update received in December 2021

- **Integrated Performance Reports** – The Committee considers the Integrated Performance at every meeting with particular focus on the metrics relating to the quality agenda.

2.5 Sub-group Reporting

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

- Infection Prevention and Control Board
- Trust Patient Safety and Quality Board *(formerly Patient Safety Group)*
- Clinical Ethics Panel – the first update was received in May 2021 following the review of the governance reporting structure
- Clinical Effectiveness and Audit Group – the first update was received in May 2021 following the review of the governance reporting structure
- Patient Experience and Caring Group
- Clinical Outcomes Group
- Medical Gas and Non-Invasive Ventilation Group Report
- Research and Innovation Report – annual update received in March 2022

2.6 Policies

The Committee approved the following policies:

- Ligature Policy – approved in July 2021
- Consent Policy – approved in December 2021.
- Incident Management Group Policy – approved in February 2022
- Duty of Candour Policy - Policy approved in February 2022

2. Effectiveness of Quality Committee

The Committee has been active during the year in carrying out its duty in providing the Board with assurance that effective internal control arrangements are in place. The Committee summarises escalations to the board at the end of every meeting.

On an annual basis, the Committee undertakes a self-assessment exercise to gauge the Committee's effectiveness by taking the views of Committee members and attendees across a number of themes. The outcome of this is then reviewed by the Committee and an action plan developed and monitored by the Committee. The self-assessment exercise took place in April 2022 (Appendix 1).

The Committee continues to review and update the associated work plan.

4. Conclusion

As described above, the Quality Committee has received assurance through the course of 2021/2022 from a number of sources.

The Committee therefore confirms that it has fulfilled its role to the Board during 1 April 2021 to 31 March 2022 in its key functions of providing assurance that that there is continuous and measurable improvement in the quality of the services provided through review of governance, performance and internal control systems supporting the delivery of safe, high quality patient care. In addition to ensuring that the risks associated with the quality of the delivery of patient care are managed appropriately.

The members of the Quality Committee would like to thank all those who have responded to its requests during the year and who have supported it in carrying out its duties.

5. Next Steps 2022 / 2023

The Committee will continue to focus its attention on the oversight of the delivery of high quality, safe and clinically effective care for the patients of CHFT. The patient experience and engagement agenda will be monitored for progress against key objectives.

Denise Sterling
Non-Executive Director / Quality Committee Chair
June 2022

Appendix 1

Self – assessment of effectiveness of Quality Committee (1 April 2021 to 31 March 2022)

Seven responses were received, with the findings outlined below:

1. COMMITTEE FOCUS: The Committee has set itself a series of objectives it wants to achieve this year

More Details

Strongly Agree	6
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	0

2. COMMITTEE FOCUS: The Committee has made a conscious decision about how it wants to operate in terms of the level of information it would like to receive for each of the items on its cycle of business.

More Details

Strongly Agree	6
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	0

3. COMMITTEE FOCUS: Committee members contribute regularly across the range of issues discussed.

More Details

Strongly Agree	3
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

4. COMMITTEE TEAM WORKING: The Committee has the right balance of experience, knowledge and skills.

More Details

Strongly Agree	7
Agree	0
Disagree	0
Strongly Disagree	0
Unable to answer	0

5. COMMITTEE TEAM WORKING: The Committee ensures that the relevant executive director/manager attends meetings to enable it to secure the required level of understanding of the reports and information it receives.

More Details

Strongly Agree	5
Agree	2
Disagree	0
Strongly Disagree	0
Unable to answer	0

6. COMMITTEE TEAM WORKING: Management fully briefs the Committee via the assurance framework, in relation to the key risks and assurances received and any gaps in control/assurance, in a timely fashion, thereby eradicating the potential for 'surprises'.

More Details

Strongly Agree	5
Agree	2
Disagree	0
Strongly Disagree	0
Unable to answer	0

7. COMMITTEE TEAM WORKING: The sub-groups report timely and clear information in support of the Committee, thereby eradicating the potential for 'surprises'.

More Details

Strongly Agree	4
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	0

This is an improvement on last year's results where one response disagreed

8. COMMITTEE TEAM WORKING: I feel sufficiently comfortable within the Committee environment to be able to express my views, doubts and opinions.

More Details

Strongly Agree	7
Agree	0
Disagree	0
Strongly Disagree	0
Unable to answer	0

9. COMMITTEE TEAM WORKING: Members hold their assurance providers to account for late or missing assurances.

More Details

Strongly Agree	1
Agree	6
Disagree	0
Strongly Disagree	0
Unable to answer	0

This is an improvement on last year's results where one response disagreed

10. COMMITTEE TEAM WORKING: When a decision has been made or action agreed, I feel confident that it will be implemented as agreed and in line with the timescale set down.

More Details

Strongly Agree	5
Agree	2
Disagree	0
Strongly Disagree	0
Unable to answer	0

This is an improvement on last year's results where one response disagreed, and one strongly disagreed

11. COMMITTEE EFFECTIVENESS: The quality of Committee papers received allows me to perform my role effectively.

More Details

Strongly Agree	2
Agree	4
Disagree	1
Strongly Disagree	0
Unable to answer	0

12. COMMITTEE EFFECTIVENESS: Members provide real and genuine challenge – they do not just seek clarification and/or reassurance.

More Details

Strongly Agree	3
Agree	4
Disagree	0
Strongly Disagree	0
Unable to answer	0

This is an improvement on last year's results where one response disagreed

13. COMMITTEE EFFECTIVENESS: Debate is allowed to flow and conclusions reached without being cut short or stifled due to time constraints etc.

More Details

Strongly Agree	6
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	0

14. COMMITTEE EFFECTIVENESS: Each agenda item is 'closed off' appropriately so that I am clear what the conclusion is; who is doing what, when and how etc. and how it is being monitored.

More Details

Strongly Agree	4
Agree	3
Disagree	0
Strongly Disagree	0
Unable to answer	0

15. COMMITTEE EFFECTIVENESS: At the end of each meeting we discuss the outcomes and reflect back on decisions made and what worked well, not so well etc.

More Details

Strongly Agree	6
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	0

16. COMMITTEE EFFECTIVENESS: The Board of Directors challenges and understands the reporting from this Committee.

More Details

Strongly Agree	4
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	2

17. COMMITTEE EFFECTIVENESS: There is a formal appraisal of the committee's effectiveness each year which is evidence based and takes into account my views and external views.

More Details

Strongly Agree	4
Agree	2
Disagree	0
Strongly Disagree	0
Unable to Answer	1

18. COMMITTEE ENGAGEMENT: The Committee actively challenges both management and other assurance providers during the year to gain a clear understanding of their findings.

More Details

Strongly Agree	4
Agree	3
Disagree	0
Strongly Disagree	0
Unable to Answer	0

19. COMMITTEE ENGAGEMENT: The Committee is clear about the complementary relationship it has with other committees that play a role in relation to clinical governance, quality and risk management.

More Details

Strongly Agree	3
Agree	4
Disagree	0
Strongly Disagree	0
Unable to Answer	0

20. COMMITTEE ENGAGEMENT: I can provide two examples of where we, as a Committee, have focused on improvements to the system of internal control as a result of assurance gaps identified.

More Details

Strongly Agree	6
Agree	1
Disagree	0
Strongly Disagree	0
Unable to Answer	0

21. COMMITTEE LEADERSHIP: The Committee Chair has a positive impact on the performance of the Committee.

More Details

Strongly Agree	6
Agree	1
Disagree	0
Strongly Disagree	0
Unable to Answer	0

22. COMMITTEE LEADERSHIP: Committee meetings are chaired effectively and with clarity of purpose and outcome.

More Details

Strongly Agree	5
Agree	2
Disagree	0
Strongly Disagree	0
Unable to Answer	0

23. COMMITTEE LEADERSHIP: The Committee Chair is visible within the organisation and is considered approachable.

More Details

Strongly Agree	3
Agree	3
Disagree	0
Strongly Disagree	0
Unable to Answer	1

24. COMMITTEE LEADERSHIP: The Committee Chair allows debate to flow freely and does not assert his/her own views too strongly.

More Details

Strongly Agree	7
Agree	0
Disagree	0
Strongly disagree	0
Unable to Answer	0

25. COMMITTEE LEADERSHIP: The Committee Chair provides clear and concise information to the Board on the activities of the Committee and the implications of all identified gaps in assurance/control.

More Details

Strongly Agree	5
Agree	1
Disagree	0
Strongly Disagree	0
Unable to answer	1

Additional Comments

"The Committee has found a 'balance' in its meetings across the last 12 months to ensure it focuses on significant quality concerns/issues whilst maintaining a comprehensive overview of all matters within its remit"

"I have seen an improvement in the coherence of the meeting agenda and papers. There is good triangulation and read across to the Quality and Safety strategy"

2. Calderdale and Huddersfield Solutions Managing Directors Report – June 2022

Calderdale & Huddersfield Solutions Limited (CHS)

MANAGING DIRECTOR'S SHAREHOLDERS REPORT

June 2022

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 are well underway on the new Learning Centre on sub-basement corridor at HRI. We anticipate completion by the end of June/early July, we have had delays with the procurement of materials.

The demolition of the old Learning Centre and Nurses Residence is now complete, the green space area has been top soiled and grass seeded. An application for charitable funds has been approved and the capital team are working with stakeholders and looking to appoint a landscape architect to design the future space.

2.1.2 Community

Our property manager is working with community colleagues and scoping a potential new property in central Halifax. An options appraisal has been completed alongside colleagues in the community division. Head of Estates is also supporting the Trust with potential locations for a community diagnostics hub with an extremely challenging timescale around capital delivery for this scheme.

2.1.3 LED Scheme

The LED scheme continues to progress at HRI albeit with challenges around timescales and delivery. The scheme remains around 95% complete, we have managed to access areas within ICU over the last month.

2.1.4 Fire Safety

The new fire alarm panels have been installed and commissioned. Fire compartmentation works are still awaiting completed architects' plans, the prototype has been approved by Capital and Trust Fire Officer and we are awaiting finalised plans in the coming weeks.

2.1.5 Portland Stone

The latest 6 monthly inspection was carried out in January with 11 panels requiring remedial action. We have instructed 10 of the panels to be repaired, with 1 of the panels in a restricted access courtyard where we have put a procedure in place to mitigate any exposure/risk. The engineers are also addressing concerns with condition C rated panels as previously discussed at CHS Board in March. A report has been provided by the structural engineers but does not fully answer all the queries raised, we are meeting with them again and are actively sourcing a suitably qualified company for a second opinion.

2.1.6 Oxygen

We are now reporting on less than 18% which is near normal levels.

2.1.7 Ventilation

The pharmacy air handling unit is currently being installed. We are working closely with our Appointed Person (AP) & Appointed Engineer (AE) to finalise the 22-23 capital plan spend on ventilation and prepare a schedule of work. Our capital team are also undertaking a feasibility study for ventilation within the existing A&E.

2.1.8 ED Development

The construction partner (IHP) have made good progress with the ground floor slabs. The steel frame is due for delivery and installation June/July. The programme indicates a completion date of July 2023.

2.1.9 Learning & Development Centre CRH

Darwin Group have been appointed as our modular build construction partner and we are now working with key stakeholders to prepare the works information and schedule of accommodation. We are working to a completion date of Quarter 1 2023 which is challenging. The bat survey results came back negative, so we are good to progress with the demolition of Dryclough Close. We are looking into the potential of adding this to Darwin's contract to enable a more efficient programme.

2.1.10 Child Development Centre CRH (Clock House, Elland)

A construction partner has been appointed and have commenced on site; completion is expected September 22.

2.2. Medical Engineering & Decontamination Service

2.2.1 Decontamination Contract Manager Position

The post will shortly be advertised for a second time as a Band 8a with the post being under Bradford Teaching Hospital Foundation Trust (BTHFT) the job description and person specification have been agreed. The field of applicants at the last rounds was quite slim, with only one applicant being deemed suitable by all short listers.

2.2.2 Decontamination Manager

The job description and person specification for the post of Decontamination Manager has been written and submitted for job matching and evaluation, with the addition of the requirement for Authorised Person Decontamination AP(D) added, once confirmed this post will be advertised.

2.2.3 Patient Monitor replacement program

ICU CRH & HRI awaiting agreement with Division for networking for installation timeframe for central station, roll out of monitors to A&E HRI has begun.

2.2.4 Philips V60 Ventilator

NaPSA_2022_002_UPDATED_25_05_22 was issued by MHRA,

All actions to be completed by 12 July 2022 which has been amended.

1. Urgently identify and locate affected devices in your organisation. Action completed.
2. Identify alternative ventilators available on site. Action completed, Breas Medical Nippy 4/4+ or Hamilton C3, however these are only temporary options.
    a. If no alternatives are available, use local procurement procedures to acquire suitable alternative devices.
    b. If no suitable alternative is available, and capacity is an issue currently (or expected imminently), additional devices are available for NHS organisations. Details for how to access these devices can be found in the 'Additional information' section of this alert. In conjunction with Clinical colleagues the Vyaire Bellvista 1000 ventilator has been identified as a replacement and 7 have been acquired from DoHSC. Update these are now commissioned and available for training and use.
3. Train all relevant staff on alternative ventilators and ensure training records are up to date. Ongoing engaging with Vyaire clinical trainers.
4. If continued use of the device is required while actions 1–3 are implemented, extra patient monitoring should be enacted as detailed in the 'Additional information' section. A backup form of ventilation must be available at all times. Not required as removed from use.
5. When actions 1–3 are complete, remove affected ventilators from use and quarantine. Not applicable.
6. Place the alternative devices into service in place of the affected ventilators. Planned to roll out once training is complete, expected time scale 1 – 2 months.
7. You may continue to use affected ventilators if there is a risk of severe patient harm due to lack of ventilator availability. A thorough risk assessment must be completed, and additional monitoring must be used (see action 4). Not required as alternative ventilator can support up to 15Lpm and early escalation to ICU is preferred Clinical pathway.

2.2.5 Roche Accu-check insight insulin pump

NatPSA_2022_004 NovoRapid PumpCart in the Roche Accu-Chek Insight insulin pump: risk of insulin leakage causing hyperglycaemia and diabetic ketoacidosis.

1. Identify whether you have any Roche Accu-Chek Insight Insulin pump devices in your organisation, or if you have provided them to patients under your care. Any affected stock should be quarantined. Identify any affected stock not issued to patients, identify patients who have been issued with the device.
2. Contact users of affected devices and undertake a patient-centred risk assessment (see additional information) to determine suitability to move onto an alternative pump based on individual risk. As stated above.
3. Identify suitable alternative pumps and use local procurement procedures to acquire them. Procurement/Medical Engineering/Clinical lead identify suitable alternative.
4. Onboard patients to new pumps and ensure an appropriate follow-up period as per standard practice and guidance for initiating pump therapy within your organisation. As stated above.
5. Patients with diabetes can continue to use affected devices if there is a lack of suitable alternative insulin therapy or if this has been deemed necessary after the patient-centred consultation. Any continued use of the affected device at any stage of the implementation of this alert requires a local risk assessment to be completed and documented (see additional information).

Actions should be fully completed in 6 months – by 26 November 2022

2.2.6 Training Compliance

CHS training compliance for Medical Devices has dipped slightly to 98%, this is still demonstrating the ability to maintain compliance. Trust compliance has increased across almost all areas, all areas below 50% compliance areas are to present their action plans to the CHFT Health & Safety Committee, CHFT have made a step forward in changing from Red to Amber, it is hoped that this will continue with the ongoing support of the Training team, which has been a key enabler for this.

Division	April	May
Surgical	69%	72%
Medicine	59%	59%
FSS	78%	81%
Community	72%	76%
Corporate	72%	78%
CHS	100%	98%
Trust	75%	77%

2.2.7 Recruitment/Vacancies

Recruitment

- Medical Engineer Bank Grade D – x 2 more posts filled, creating a buffer.
- Medical Engineer Grade E – post now filled, and incumbent started.

Vacancies

- Decontamination Manager awaiting approval.
- Medical Engineer Grade E Gapped.
- Medical Engineer Apprentice Grade D schedule 21 Gapped.

Interviews for Grade D planned for 16th June.

Interviews for Grade E planned for 22nd & 27th June we have decided to interview a larger pool of candidates, any suitable applicants that are not successful will be added to the talent pool, in the event we have a similar vacancy soon we can draw from the talent pool without the need for interview.

2.2.8 Medical Engineering CRH

There have been delays to the commissioning of the medical gas supplies (MGPS) which have meant we have been working using our contingency plans, this is planned to be resolved as the MGPS are to be commissioned on the 28 June.

2.2.9 Authorised Persons

As the Estates team are experiencing issues with recruiting and maintaining AP roles, the Head of Medical Engineering has offered to support the AP(D) role and has booked the course for August, with the addition of the Decontamination Manager post holding AP(D) once recruited to this will aid with the resilience of the Company as we move forward while providing mutual support. We are also exploring some of the other AP roles, like Pressure Systems, which the Head of Medical Engineering has previously been certified in.

2.2.10 Medical Device Training

The Medical Device Training Team have been working with Microsoft and THIS to develop an entirely digital database with digital signature, which would transform the way we record and manage Medical Device Training, this could then potentially be built upon and set the standard for other Trusts to follow, it would also offer the opportunity for the transfer of records between Trusts.

2.3. Facilities

2.3.1 Enhanced shuttle service

The Broad Street Plaza – CRH, Park and Ride service has been put on hold until April 2023. Transport has everything in place except for recruitment for when a decision is made to proceed with the service.

2.3.2 Staffing

Staffing remains challenging because of 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 Domestics services manager is working with the job centres and communications team to get adverts out onto social media.

We are also currently part of a work group with SWAP which stands for sector based work academy recruitment programme in both Calderdale and Kirklees job centres. Our recruitment team and service managers are spending a day every 2 months in both job centres to talk about what we can offer and divert people our way.

We are also signing up for a taster placement scheme which means that we will take 10 x people into each of our services for a 2hr taster in each of the services, then when a role becomes available, we guarantee the person an interview.

2.3.3 National Cleaning Standards

The National Cleaning standards “went Live” on 3 May. There has been teething issues, which was to be expected but a meeting has been arranged with all parties involved to ensure all processes are the same and being followed

2.3.4 BICS (British Institute of Cleaning Science)

Training has improved whilst still slow, due to staffing difficulties. 100 staff now have their BICS Licence to practice and training will continue each week until all domestics have been captured.

2.3.5 - Duty Manager

We intend to introduce an out of hours duty manager role at HRI, as from September and as such are currently going through a consultation period with our janitors who will no longer be

required to cover nights, given that the Duty Manager will be fully trained and operational in all Facilities services. The consultation process is going better than expected and all preferences have now been received, with various position moves to take place, given that one janitor has requested to move to a portering role, one to a waste role and one to an Estates role. There will still be a requirement for 3 or 4 domestics overnight, to support the Duty Manager and one janitor has requested to return to daytime shifts.

2.3.6 - Transport external audit
The Transport external audit takes place on 14 June to ensure that CHS have all the relevant processes / protocols are in place and whether we were legal in all our operations. The outcome will go to the Traffic Commissioner.

2.3.7 - Linen Tender
The Linen tender is back out to market as of 19 May and a site visit from the bidders has taken place to look at logistics, delivery areas, collection area. The contract award will take place on 7 July with a commencement date of 1 October 2022.

2.3.8 - Retail
The seating area has reopened in the Café 1831, which has seen an increase in income.
Southside dining provided a week of commonwealth menus for staff which was well received.
All but 2 members of Compass staff have transferred across to CHS T&C's.

2.3.9 - Scanquo

HRI agreed to be part of a trial at the end of 2021 to allow a company called scanquo onto site and scan 2 x wards (21/22)
The concept of scanquo is to

- Allow us to Benchmark so we are utilising staff in correct areas using correct hours
- Scoping new areas of work – allows us to give accurate timings from the offset that is evidence based
- Allows us to save time and money and these savings in business cases
- More accuracy due to 3d technology i.e. showing dead floor space
- Ability to capture work carried out that we don't get revenue for

It accurately reflects activity –

- Option to change discharge frequency ie if acute floor/ED is busier than normal
- Option to add in touch point cleaning/outbreak clean/deep clean
- Option to change function of areas ie if discharge lounge becomes a ward
- It can work out costs for CHS and AFC staff so we can cost effectively dependent on which staff are used

We have been given the go ahead to progress with the work and a meeting took place on 9 June to discuss next steps. Since then, we have been working on the floor plans of HRI to highlight areas cleaned, before sending to the company.

2.4. Procurement

2.4.1 Materials Management

May was challenging again due to Covid amongst the management & supervisor team at HRI, one member of staff requiring urgent admission to hospital and another member of the team unable to work due to back issues. This was in addition to a member of the CRH team on long term sick and planned annual leave at both HRI & CRH. As usual, every single member of all teams pulled together to back fill as normal to maintain our business-as-usual service.

Both members of the Inventory Management Team had to postpone all work due to backfilling in theatres for most of May.

Lateral flow test stock deliveries reduced in quantity to the designated areas in the last 2 weeks of May however we are waiting for the Screening Team to confirm they are commencing with the daily testing of patients on Day 3 & 7 which will tentatively commence the 2nd week of June. The Supply Chain Manager has had further discussions with the Screening Team to put in place a loose process for the management of the test kits as the team are holding a different unit of issue to the boxes being distributed by matman.

A member of our team completed his last shift in X-Ray on the 31st May and we successfully appointed into this role which will commence Monday 6th June.

Personal Development Reviews (PDRs) have taken place with approx. ¼ of the team having had their PDR in May. All the matman and stores teams have their PDR dates booked on ESR.

Considering the impending CQC visit, all matman staff will be taking part in an internal audit spot checking areas w/c 13th & 20th June.

Finally, there was an urgent recall of type IIR surgical face masks which was issued to us at 4.22pm on Weds 1st June just before the Jubilee BH weekend. A plan was put into place with a skeleton team back in work on the 2nd June to swap 80,000 face masks from all clinical areas that could be accessed.

NHSSC (NHS Supply Chain) / WYAAT (West Yorkshire Association Acute Trusts):

- May saw an increase in items being demand managed jumping up from 29 items to 68 of which we are affected by 75% of those items. Patient dry wipes needed to be purchased direct again and the Portex supply disruption of epidural and spinal packs is challenging due to the necessity to change system. The Supply Chain Manager has been working with the trust anaesthetic lead on finding a suitable alternative for all theatres and LDRP. This piece of urgent work has not concluded yet.
- More consumables are in the process of being evaluated however clinical engagement is required due to alternatives not being like for like e.g. NICE guidance and research is required for an obstetric consumable.
- The recent switch of hand towel to Metsa has meant we have not been subject to a second price increase from Kimberly Clark.
- WYAAT agreed to submit all our PO data back to Tower 4 to review minimally invasive due to Leeds not being able to progress a contract for WYAAT in the last year.
- Integrated Care System (ICS) evaluation of crutches and walking frames took place on the 18th May with representation from acute trusts, mental health trusts and Leeds city council. The group agreed to standardise to one supplier for walking sticks and crutches with further evaluation to take place in June for the walking frames.

Scan4Safety:

- An additional set of Standard Operating Procedures (SOPS) was submitted to theatres for review with clinical suggestions for change already back from the first set.
- The information governance and security piece of work around the VPN tunnel has been suggested for completion around the 20th June which means potential testing could take place.

- The first WYAAT admin team meeting took place so all WYAAT trusts could raise issues and share learning experiences. The document is with Omnicell for review.
- The site visit to Chapel Allerton, Leeds has been planned for Monday 20th June to see how the team there work round the stock module issues identified by our team.

2.4.2 Category Management

The team have been making great progress with the implementation of the next stages of the Atamis modules and functionality. From the input of data we are now starting to build up a quantifiable picture of the requirements of the Trust and CHS.

- Live contracts - 675
- Live active projects – 36
- Projects completed via Atamis - 51
- Contracts ending this financial year - 433
- Future workplan projects - 563

The Operational Procurement Team have been trialling Atamis for Quick Quotes as the Atamis solution will replace Multiquote for them from August 2022. When we first started implementing Atamis in Nov 2021, an onboarding email was sent to all the suppliers of CHS/Trust to advise them of the move and to register their details on the Atamis portal to ensure they received all future procurement opportunities. Most suppliers have registered but the next piece of work is to liaise with the remaining suppliers and assist with the onboarding where necessary to ensure they do not lose any local opportunities i.e. SME's (Subject matter experts) We are also in the stages of planning a Local Supplier engagement day for later in the year.

Major Projects Programme Update:

- Tele dermatology – Contract awarded, contract draft stage
- Laundry – Tender deadline 24th June
- CRH Carpark – Tender deadline 30th June
- CRH Construction Partner – Tender due to market June
- Trust-wide Courier Services – Tender due to market June
- Reconfiguration – ongoing engagement

The two new Assistant Category Managers are now in post. The mentorship sessions are every fortnight with a view to upskill and develop the team, the team are asked to come to the session with a specific requirement or project that they need guidance with so that we can work through them as a team.

2.4.3 Operational Procurement

During the last month the team have dealt with various single source requests:

- Pearson's Education for apprenticeships & end assessments for £20k, this has been passed over to the Category team for a full contract to be put in place
- Weqas accreditation laboratories for £10k
- Blood fast single source addendum for radioactive isotopes, this has been increased from £10k to £25k to cover the remainder if the financial year.
- Fuel deliveries for MR scanner generators for £30k

The team have also placed several orders via frameworks:

- Standing order for Omnipaque from GE via NOECPC framework for a value of £77k to cover May to the end of the financial year
- CT fast flow syringes from Bracco via an NOECPC framework for a value of £70k to cover the financial year.
- Bone stimulators from Bioventus via an NHSSC framework, this was a one-of order for a value of £22k

Dump the junk – £2,610 cost avoidance saving achieved by reusing patient tables, lockers, chairs and a couch via the dump the junk initiative.

WYAAT meetings have been attended re patient meals and milk contracts, these will be taken into the category team moving forward.

We have continued to upload contracts to Atamis, 25 have been added to Atamis during the month.

The team met with Alexandra, the main uniform supplier, due to issues surrounding invoice queries. We are looking to move to full EDI ordering / invoicing via PEPPOL. The team are currently working with the supplier and stakeholders to create a comprehensive catalogue including all embroidery to allow this process to work seamlessly. We hope to go live with this in the next 2 months.

The buying team are beginning to use the Spend Comparison tool to benchmark pricing of products, due to supplier price increases from 1st April this hasn't returned savings however we hope that after Q1, when new data is inputted into the system, this may become more useful.

We are completing a project around mobile telecoms, any connections with 3-month zero usage have been identified and the budget holders contacted. Those that have been confirmed as no longer required have been scheduled to disconnect and those that we have not received any response to have been suspended for 30 days pending disconnection. There is a potential saving of approx. £50k when all connections have been disconnected.

As agreed with finance colleagues we have implemented a 3-day SLA for the team to turn round finance requests, this includes the changing of budget holders and hierarchies. During the period we have dealt with 244 requests and had 0 breaches. We have 3 i-Proc training sessions scheduled for June via MS Teams with 34 attendees currently booked across the sessions.

The team have processed 103 catalogue updates (deletions, price changes, full catalogue updates) since the beginning of the new financial year. This helps us ensure our purchase orders contain the correct product data and pricing to try and limit invoice queries.

Scan4Safety - There is currently and issue with the interface between the catalogue solution GHX Nexus and the IMS Omnicell. Files are intermittently failing to be processed by the Omnicell server and no error messages occur to advise this. this has meant we have mismatched data between the 2 systems and have done a full comparison between the two to identify the data that needs to be reloaded. We await a fix for the interface issue and the files are ready to be loaded by the LTH catalogue team once this has been completed.

We have a new Assistant Buyer in post who joined us 6th June, this follows the 3 new starters into the position of Buyer from 25th April. The Operational Procurement Team is now at full capacity, and we are currently training all the new starters.

3.0 CHS

3.1 Spotlight Awards

April/May 2022

The Procurement and Materials Management Teams were awarded the GOLD Spotlight Award for May 2022.
Following an urgent product recall which was received after 5pm on Wednesday, 1st June to remove 2 x Type IIR masks from circulation, the team were contacted out of hours for volunteers to come to each site from 7:30am Thursday, 2nd June, which was the first day of the Jubilee Bank Holiday. The team all gave up their Bank Holiday plans to come onto site to ensure the safety of the Trust's staff and patients. The team, led by the Supply Chain Manager successfully delivered the following:

- 40,000 masks replaced in clinical areas at CRH.
- 40,000 masks replaced in clinical areas at HRI.
- 266,000 masks quarantined in both MatMan departments and the Laundry.
- 10,000 masks left with Acre Mill Reception.
- An urgent submission placed to NHSE for 500,000 replacement masks on Tuesday.
- A red border e-mail was circulated on Monday 6th June to capture the remaining stock.

3.2. Finance

3.2.1 In Month Period 2

The in-month position shows a £0.03m surplus against a plan of £0.02m with a £0.01m favourable variance. This position results from the over recovery of income (£1.08m) due to an increase in the goods and services being transacted through the company offset by an overspend on non-pay (£0.79m) (adverse to plan). Pay is overspent by £0.03m due to vacancies in Senior and middle grade positions. Non pay is overspent by £0.79m due to an increase in goods and services being transacted through the company Total income is above plan by £3.58m which reflects the increase in income invoiced for goods and services requested by CHFT.

3.2.2 Forecast 2022/23

As at month 2 the forecast position for 22/23 is expected to come in on plan.

3.2.3 Capital Plan- Month 2

CHS have set out a capital plans of £1.487m and is in line with plan.

3.2.4 CIP 2022/23 Estates and Facilities

The target for CHS Estates and Facilities is £1,019m, £711k estates portfolio and £308k commercial portfolio. At this stage schemes of £871k have been identified as recurrent relating to energy, waste, and staff efficiencies in cleaning and portering. Managers and Heads of Service are currently working on CIP plans to deliver the target in conjunction with CHFT.

3.2.5 CIP 2022/23 Procurement

The target for CHS Procurement is £750k. At this stage schemes of £750k have been identified as recurrent relating to NHS supply chain and maintenance contracts and are at GW2. A plan has now been worked up with forecast savings of £750k for the end of the year.

3.3 Workforce

3.3.1 Attendance

CHS sickness rate for May is 4.7% comprising LTS 3.2% and STS 1.5 %. This a slight reduction on May's figures and is below the Trust rate of 6.3%. Stress and anxiety continue to sit outside the top 5 reasons for absence. Where cases are reported there is a wraparound plan of support available.

3.3.2 Appraisal and Essential Skills Training

Mandatory training (EST) KPI's are green with all modules achieving the target of 90-95%.

Outstanding return to work interviews have been followed up with Managers in order to conduct these and to update ESR accordingly.

Appraisal season is May to September and current compliance is at 12%. Of the 392 colleagues eligible for an appraisal, 54 have had a review within the current financial year. Staff on long term sickness, maternity, and new starters within their first 6 months of employment are excluded from these figures.

3.3.3 Leavers

9 colleagues left CHS during May as follows:-

1 - Promotion outside the Company (Med Engineering)
2 - Ill Health Dismissals
1 - Dismissed - dishonest completion of pre-employment checks (DBS issue)
1 - Returned to university
1 - Obtained a role in a private sector hospital - no weekends
1 - CHS is second job - left for work life balance to have weekends with family
1 – Secured a housekeeper role in the Trust
1 – Age retirement

3.3.4 Organisational change - Facilities

Consultation continues in relation to the disestablishment of the Janitor role and the introduction of 3 Duty Manager posts who will work overnight (including operationally across all services) on a rota basis. Currently there is no out of hours management cover and this impacts on operational effectiveness. Individual preferences for redeployment have been sought which will necessitate a competitive process in some instances. The majority of staff are satisfied with the choices available. The change will be pay affecting for some staff and short term (12 m) pay protection arrangements will apply. Unions continue to be involved in discussions.

3.3.5 Union Recognition and Facilities for time off Agreement

A CHS Recognition Agreement has been drawn up to share with union colleagues prior to the next JCC on 29 June. This has been shared with our legal advisor and we have agreed an additional point to the collective bargaining paragraph, highlighted in blue text below.

The relationship between the Company and its trade unions is partly based on collective bargaining. This is defined by Section 178 of the Trade Union and Labour Relations (Consolidation) Act 1992. Collective Bargaining is a voluntary process between management and those trade unions representing employees of the Company aimed at reaching agreements which regulate working conditions, pay and terms and conditions of service. "BOD will have final decision-making rights in relation to pay for none agenda for Change staff". (Note: that this is not dissimilar to the wording used in the Trust when we had differential arrangements for managing local senior managers pay.)

3.3.6 CHS Terms and Conditions update

The draft external market testing report in relation to the above that has been shared with BOD and discussed with the SMT. Data is being collated over a 6-month period, including financial data, to inform a paper for August Board. Following any board of director recommendations, the paper will then be taken to CHFT's Nomination and Remuneration Committee in September/October.

4.0 KPIs

CHS provide 66 KPIs to CHFT (HRI site) of which just **3 did not** achieve Green Target.

- **Medical Engineering -** High Risk PPMS – **AMBER – 75.65%** against target of >80%.
- **Medical Engineering -** Low Risk PPMS – **AMBER – 55.80%** against a target of >60%
- **Estates –** Statutory PPMs – **AMBER – 97.56%** against target of 100%

CHS also provide 12 KPIs to CHFT Acre Mill site of which **ALL but one achieved Green Target**

- **Cleaning** – Functional Risk 2 – **RED - 70%** against target of >92%.

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)
- Reduced oxygen flow rate & pressure drop Ward 11, HRI (16)

6.0 Recommendation

Shareholders are asked to note the contents of the report.

APPENDIX 1

Risk Register C H Solutions – June 2022

C H Solutions	Number of Risks	Change in Month
Burgundy Very Hi Risks	4	0
Red Risks High	2	0
Amber Risks Moderate	26	-2
Green Risks Low	7	-2
Total	39	-4

Risk ref + score	Strategic Objective	Risk	Executive Lead	Jan 22	Feb 22	March 22	April 22	May 22	June 22
CHS Risk 6903 (CHFT 7444 (12)	Keeping the base safe	Resus – Collective risk to maintain compliance / upgrade There is a collective risk in regard to Resus from individual (12) risks due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.	Managing Director (SS) Head of Estates (TD)	=20	=20	=20	=20	=20	=20
CHS Risk 7271 (CHFT 7442 (12)	Keeping the base safe	ICU – Collective risk to maintain compliance / upgrade There is a collective risk in regard to the ICU from individual (12) risks due to insufficient capital funding and operational plans to allow estates maintenance staff and contractors to carry out refurbishment upgrades / life cycling resulting in unplanned failure/ Injuries to patients & staff.	Managing Director (SS) Head of Estates (TD)	=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) Head of Estates (TD)	=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 8133	Keeping the base safe	There is a risk of: A reduced oxygen flow rate and pressure drop due to the oxygen infrastructure to ward 11. Caused by: Ward 11 only has one oxygen outlet per 2 beds, meaning a decision must be made on which bed can receive high flow oxygen. Resulting in: One bed or several beds having no oxygen supply	Managing Director (SS) Senior Estates Officer (DS)	=16	=16	=16	=16	=16	=16
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 due to inadequate fire compartmentation and the increasing number of electrical equipment stored on corridors, evacuation routes and around fire exits resulting in potential fire spread and subsequent harm during evacuation leading to damage to buildings, staff, patients, visitors and contractors and a failure to deliver clinical services.	Managing Director (SS) Head of Estates (TD)	=15	=15	=15	=15	=15	=15

The Risk Register has been noted by CHS Board

3. Board Sub-Committee Minutes in the Review Room

- Audit and Risk Committee – 26.04.22
- Charitable Funds Committee – 11.05.22
- Finance and Performance Committee – 03.05.22 and 07.06.22
- Quality Committee – 20.04.22 and 16.05.22
- Workforce Committee – 12.04.22

Calderdale and Huddersfield NHS Foundation Trust

Draft Minutes of the Audit and Risk Committee Meeting held on Tuesday 26 April 2022 commencing at 10:00 am via Microsoft Teams

PRESENT

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

IN ATTENDANCE

Andrea McCourt	Company Secretary
Gary Boothby	Director of Finance
Helen Higgs	Head of Internal Audit, Audit Yorkshire
Shaun Fleming	Local Counter Fraud Specialist, Audit Yorkshire
Jim Rea	Managing Director, Digital Health
Ric Lee	Engagement Director, KPMG
Salma Younis	External Audit Manager, KPMG
Leanne Sobratee	Internal Audit Manager, Audit Yorkshire
Amber Fox	Corporate Governance Manager **(minutes)**
Liam Stout	Staff Elected Governor
Kim Smith	Assistant Director of Quality and Safety
Lisa Cook	Head of Risk and Compliance **(for item 05/22)**
Helen Hirst	Designate Chair **(Observer)**
Jade Kerrigan	Student – Quality and Risk Team **(Observer)**

20/22 APOLOGIES FOR ABSENCE

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

The Chair welcomed Helen Hirst, designate Chair to the meeting who was in attendance as an observer as part of her induction.

Apologies were received from Denise Sterling, Philip Lewer and Kirsty Archer.

21/22 DECLARATIONS OF INTEREST

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

22/22 MINUTES OF THE MEETING HELD ON 25 JANUARY 2022

The minutes of the meeting held on 25 January 2022 were approved as a correct record subject to the following amendment:

- Bottom of page 8 - External Audit – Jenny Hibberd*

OUTCOME: The Committee **APPROVED** the minutes of the previous meeting held on 25 January 2022 subject to the amendment above.

23/22 ACTION LOG AND MATTERS ARISING

The action log was reviewed and updated accordingly.

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

24/22 RISK MANAGEMENT PROCESS DEEP DIVE

Kim Smith, Assistant Director of Quality and Safety and Lisa Cook, Head of Risk and Compliance presented a deep dive into the Risk Management Process.

The Head of Risk and Compliance updated the Committee on the recent improvement work undertaken on the risk management process. The key points to note were:

- Review of the Risk Management Strategy and Policy has been completed
- Terms of Reference for the Risk Group have been reviewed and updated
- Work is taking place with Divisions to gain some greater consistency and level of understanding around the management of risks
- Discussion has taken place at the Risk Group regarding a review and refresh of risks that have been on the risk register for a prolonged period of time.

RH recognised there is lots of work still to be done around learning and training in risk management in the Divisions and asked if the team are happy with the level of buy in and commitment from Divisions. The Assistant Director of Quality and Safety explained the buy in has increased significantly since using the risk register as a learning tool. The risk team are using a critical friend approach focusing on development. She explained the focus of the Risk Group has been improved and Divisions understand the need to identify and to challenge how risks are described.

AN stated he is pleased to hear about divisional engagement at the meetings. The Head of Risk and Compliance agreed there is an improved buy in and commented there are now clear flowcharts about the risk management process and further detail about specific risks.

AN stated that for some risks there is a need to accept a level of risk. There also needs to be more discipline around setting the target scores and more thought on the actions required to meet the target score. The Head of Risk and Compliance responded that work has taken place on the risks that we tolerate and further work needs to take place on the target scores. She re-assured the Committee that a clearer process will be in place to monitor risks and risk scores.

OUTCOME: The Committee **NOTED** the Risk Management Process Deep Dive and ongoing work in the Risk team.

25/22 REVIEW OF SUB-COMMITTEE TERMS OF REFERENCE

1. Data Quality Board

The Chair confirmed the changes to the Data Quality Board terms of reference detailed were minor and relate to the membership of the Board.

2. Risk Group

The Head of Risk and Compliance confirmed a minor update has been made to the terms of reference on the membership.

RH asked if the Director of Corporate Affairs should be added to the Risk Group membership. The Assistant Director of Quality and Safety responded that this needs to be understood further and may be a future change to the terms of reference.

The Company Secretary confirmed she attends the Risk Group from a strategic risk and High Level Risk Register point of view which will need to be reviewed once the Director of Corporate Affairs is in post. She suggested it may be helpful for the Director of Corporate Affairs to attend a meeting as part of her induction in which the terms reference can be reviewed.

AN highlighted that the High Level Risk Register (HLRR) reports to the Board of Directors three times a year which should be included in the terms of reference under reporting.
Action: The Assistant Director of Quality and Safety to update the reporting of the High Level Risk Register which reports to the Board of Directors three times a year in the Terms of Reference.

AN asked if there were any links to the Weekly Executive Board (WEB). The Company Secretary responded that prior to the Risk Register going to Board there could be a review for sign-off at the WEB which is worth re-introducing as it ensures the Executives sign up to the risks.

The Director of Finance flagged there may be duplication if the High Level Risk Register reported to WEB as he confirmed it is presented at the Divisional Review Business Meetings where Divisions flag new risks and risks removed. He confirmed this meeting is attended by the majority of the Executive team.

The Assistant Director of Quality and Safety suggested developing a flow chart for the terms of reference to confirm the reporting of the HLRR for clarity and to avoid duplication.
Action: The Assistant Director of Quality and Safety to develop and include a flow chart of the reporting structure for the HLRR in the Risk Group Terms of Reference.

OUTCOME: The Committee **APPROVED** the updated Terms of Reference for the Data Quality Board and Risk Group subject to the changes noted above.

26/22 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

1. Review of Losses and Special Payments

The Director of Finance presented a report summarising the losses and special payments for quarter 4 2021/22. The key points to note were during Q2 the Trust wrote off a debt just over £100k in relation to overseas visitors. The Director of Finance reported they have been liaising with NHS England/Improvement (NHS E/I) and Treasury in relation to another loss and special payment relating to an IT contract and became aware that any write off in excess of £100k requires Treasury approval and this has been re-instated.

OUTCOME: The Committee **NOTED** the Review of Losses and Special Payments report.

2. Review of Waiving of Standard Orders

The Director of Finance presented the quarter report showing fifteen waivers during quarter 4, 2021/22 at a total cost of £643,404.99.

The Director of Finance highlighted in relation to February, an urgent repair for Thermofisher was needed and gave assurance that the £78K was good value for money with a bundle awarded to Thermofisher which is a comparatively cheaper than the other two suppliers (£85k and £114k).

RH asked why the Luna Carts was a single source tender and challenged that there seemed to be a high number of items in the fourth quarter for single source and asked for assurance that the Trust are getting value for money. The Director of Finance responded that this was in relation to consistency with products across the Trust for Luna Carts. This also related to capital monies being allocated at very short notice which does not support a full tender process.

AN asked what the timescales were for a full tender process. The Director of Finance described joint working with the Health Informatics Service to be ready to respond quickly to bids for digital funds made available throughout the year and the Managing Director for Digital Health added that the challenge is the timescale for bidding which affects the ability to go to a tender process due to the timeline allocated to complete the project.

The Director of Finance added that it was noted at a recent Joint Liaison Committee that a procurement system, Atamis is being introduced to review what is purchased over 12 months which should put the Trust in a better position.

OUTCOME: The Committee **NOTED** the Waiving of Standing Orders report for quarter 4, 2021/22.

27/22 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 Q4 2021/22.

The report was presented at the WEB prior to the Audit and Risk Committee.

The report looks at all recommendations open during the last year including any that were overdue that were raised prior to the year.

- 116 of 164 recommendations have been implemented which equates to 71%
- 34 recommendations were implemented since the last quarter
- 16 recommendations are overdue where a revised date has not been agreed
- 19 recommendations are overdue with a revised target date agreed
- 18 of the 35 recommendations overdue relate to the medical directorate three main audits - Consultant Study Leave, Consultant Job Planning and Delegated Consent
- Lots of chasing has taken place during the last quarter.

The Internal Audit Manager confirmed Trust staff have been contacted about the overdue recommendations, including the Medical Director who responded that the consultant study leave recommendations will be implemented by the end of April 2022.

Good progress has been made on follow ups during the last quarter. A total of 6 out of the 7 recommendations relating to Risk and Complaints Management that were overdue last time have now been closed. One remains open with a target date of the end of June 2022.

The Director of Finance stated a paper relating to Consultant Job Planning is due at the Business Case Approvals Group this week and progress has been made. He acknowledged the programme has slipped; however, the Trust have invested some significant sums to complete this and revised timescales will be confirmed this week. This

work will support productivity and will be discussed at a number of different forums. The Chief Executive is challenging progress on closing this recommendation.

AN suggested a further push in May to get these recommendations closed off with a reflection to understand why it took so long. The Director of Finance acknowledged a number of these recommendations had an original target date before the Covid-19 pandemic.

The Internal Audit Manager explained the target date for the Delegated Consent recommendations has been pushed back by six months to 31 October 2022 and there is detailed ongoing work with divisions on this and the need to review action plans. The Internal Audit Manager agreed to follow up further on the status of responses. RH challenged that six months was a long time to extend a target date and suggested three months would be more reasonable.

Action: AN to contact the Medical Director regarding the three audits with overdue recommendations cc Chief Executive.

The Assistant Director of Quality and Safety confirmed the one outstanding action on Risk and Complaints Management is virtually complete and expects to close this in the next few weeks ahead of the deadline. She explained lessons learnt will be shared as a result of Serious Investigation (SI) panels. The Head of Risk and Compliance confirmed the Trust are currently providing information to Audit Yorkshire who are looking at SI's to gain an external view on the SI process.

2. Internal Audit Progress Report

The Internal Audit Manager presented a report which details the progress made by Internal Audit in completing the Internal Audit Plan for 2021/22. There were:

- Six assurance report finalised during the last quarter – significant assurance opinion
- The Board Assurance Framework and Financial Transactions audits which are key audits which help inform the Head of Internal Audit Opinion have been completed
- Two reports with significant assurance are still in draft.

The Internal Audit Manager confirmed they have identified 60 days of audits that will be cancelled this year, which has been agreed by the relevant Executive Director and approved by the Director of Finance. Detail is included in the paper on the reason for cancelling these audits. Two of these audits relate to limited assurance opinion reports from last year, Delegated Consent and the Portable Medicines Trolley audits. Limited assurance reports are usually re audited the following year; however, these audits are included in the 2022/23 plan with plans to re-audit imminently.

RH asked the Head of Internal Audit how the position re audit completion impacts on the internal audit opinion, acknowledging the target has not been hit in terms of number of audits completed. The Head of Internal Audit confirmed they have completed enough work to provide an internal audit opinion, which provisionally is a significant opinion. The Internal Audit Manager added that compared to the previous two or three years there has been a reduction in the number of limited assurance reports, with only one limited assurance report in the current year.

OUTCOME: The Committee **APPROVED** the Internal Audit Follow Up Report and Progress Report and **APPROVED** the removal of 60 days of audit from this year's plan.

3. Internal Audit Plan 2022/23

The Internal Audit Manager presented the Internal Audit Plan for 2022/23. The key points to note were:

- Previous three-year plan ended in 2020/21
- Last year due to Covid-19 a one-year plan was agreed
- Met with all Executive Directors at the Trust except the Director of Transformation and Partnerships
- Plan was approved at Executive Board
- Likely changes in year for 2022/23 due to Covid-19.

AN asked if Controlled Drugs and Delegated Consent would re-appear in this operational plan. The Internal Audit Manager confirmed the Delegated Consent audit will be added and confirmed the Controlled Drugs has been re-titled Portable Medicine Trolleys which is included in the 2022/23 plan.

AN asked the Director of Finance for an update on the Business Case audit and if this audit will also look at benefits realisation, which the Director of Finance confirmed it would. The Commercial Investment Strategy Group changed to the Business Case Approvals Group from 1 January 2022 with a more rigorous timetable.

AN proposed three challenges to the Strategic Plan:

1. No items included on the Green Plan
2. No items on the impact or response to Integrated Care System (ICS) and Place arrangements
3. Asset management – will this pick up a wider review of how to maintain all the assets.

In terms of 3, the Managing Director for Digital Health confirmed scan for safety assists with this and part of this funding is to audit the assets internally. He confirmed this can include IT hardware assets and software license contracts. The Internal Audit Manager and Managing Director for Digital Health reviewed asset management as part of this year's audits given the amount of investment.

The Director of Finance responded that the Green Plan and ICS audits seem reasonable requests and need to be reviewed in terms of measurements as this also affects other Trusts. The Director of Finance is a member of the ICS Capital and Estates Board where the ICS Green Plan was agreed with 40 actions which each organisation will interpret. The challenge will be where to get the assurance that the Trust Green Plan matches the ICS Green Plan and delivers the expected overall impact on the carbon footprint. AN, Chair of the Green Planning Committee, suggested it is more about independent assurance on the outcomes expected.

Action: Internal Audit Manager to consider how to incorporate the Green Plan and ICS arrangements in the Strategic Plan for the second and third year of the plan.

The Director of Finance suggested there are a number of days allocated to the Director of Corporate Affairs in the plan and the ICS audit would be a relevant audit to be picked up here.

AN recognised the challenge in getting the audits completed and asked the Director of Finance how this ongoing challenge can be improved. The Director of Finance confirmed the position has been worse over the last few years due to access to colleagues, isolation

and infection prevention and control requirements. He suggested once the plan is set that the audit executive owners are signed up to the plan and timescales. AN suggested the Internal Audit Manager reminds Executive Directors of audits that are coming up for the next quarter when attending Executive Board.

OUTCOME: The Committee **APPROVED** the Internal Audit Plan for 2022/23 subject to the Delegated Consent audit being included.

4. Significant and High Assurance Reports and Internal Audit Monthly Insight Reports (E3)

Six significant assurance reports and one advisory report, including the internal audit monthly insight reports (E3) were available in the review room.

OUTCOME: The Committee **RECEIVED** the significant assurance reports and advisory report and the Insight reports for January, February and March 2022.

28/22 LOCAL COUNTER FRAUD PROGRESS REPORT

1. Local Counter Fraud Progress Report

Shaun Fleming, Local Counter Fraud Specialist presented the Local Counter Fraud progress report and provided an update on current investigations. The key points to note were:

- Counter Fraud newsletter is available in the review room
- Counter Fraud survey has been completed and a report will be brought to the next meeting
- Counter Fraud standards return will be reviewed at the next meeting
- Counter Fraud master classes will continue with directed sessions for Departments to increase uptake
- Counter Fraud Champions have been recently introduced and the Company Secretary is the Counter Fraud Champion for the Trust
- Counter Fraud Functional Standard Return (CFFS) return to be verified by the Director of Finance and AN with a deadline the end of May 2022, highlighting the issues responding to Component 3 of the return
- Counter Fraud Plan for 2021/22 will be completed to the full planned days.

Liam Stout highlighted that prior and after to the upgrade to the Powerchart software it gives you an option to download a package and was not sure if this was a software issue or was malicious. Liam confirmed he has been trying to disseminate information to staff. The Local Counter Fraud Specialist confirmed he has received no reports on this software.
Action: Managing Director of Digital Health to follow up on the feedback regarding the upgrade to the Powerchart software with the team.

RH supported the encouragement of maximum attendance at the Counter Fraud master classes to increase awareness and congratulated the team for delivering the plan this year.

OUTCOME: The Committee **RECEIVED** the Local Counter Fraud Progress Report and Counter Fraud newsletter for March 2022.

2. Anti-Fraud, Bribery and Corruption Workplan

The Local Counter Fraud Specialist presented the draft Counter Fraud workplan for 2022/23.

OUTCOME: The Committee **APPROVED** the Counter Fraud Workplan for 2022/23.

29/22 EXTERNAL AUDIT

1. VFM Risk Assessment

Ric Lee, KPMG Engagement Partner, presented the Value for Money risk assessment for 2021/22 and highlighted no significant risks have been identified to date.

Salma Younis, KPMG confirmed the assessment covers the three domains. The key points to note were:

- No significant risks identified with no issues anticipated
- Summary of findings for each significant risk included in the report to support the assessment
- Annual auditor report will be issued in June 2022.

The Director of Finance confirmed the proposed plan for next year is for a £20.1m deficit as opposed to the £23m deficit plan presented to the last Board meeting. This is an improvement of £3m which will be described at the Board next week.

RH asked if any reference to the Turnaround Executive, now the Effective Use of Resources Group, should be flagged up in the assessment. As part of this, he added that the Trust have an Agency Spend Group which is also a key control in terms of looking at agency spend. Ric Lee responded that the arrangements in place are covered to the end of the financial year and these conclusions will be reflected in the auditors reports and if good practice can be evidenced for the year this can be reflected in the final commentary.

Salma Younis confirmed the Deputy Director of Finance referenced these groups; however, these groups are not referenced in the report and can be added if needed. AN suggested including this evidence would provide assurance that the Trust are doing everything they can to mitigate the risks.

AN asked if the 2022/23 deficit would change the VFM assessment. Ric Lee confirmed an opinion or conclusion on value for money opinion is not issued any more. A commentary is provided on any significant weakness on value for money. He explained other Trusts have had a significant deficit where significant weaknesses have not been reported due to the arrangements in place and steps taken to address this. The national audit framework guidance is followed on value for money, which highlight any weaknesses.

OUTCOME: The Committee **NOTED** the Value for Money (VFM) Risk Assessment.

2. Benchmarking Q3 Provider Finance Return (PFR) Report

The External Audit Partner, KPMG presented the Q3 PFR benchmarking report for information. The key points to note were:

- Page 4 – the Trust have spent 75% of their agency costs ceiling and are within the agreed ceiling
- The Trust have controlled agency costs throughout the year

- Capital spend (page 6) will change next year with increased spend as part of reconfiguration.

Covid-19 expenditure benchmarking (page 7) is given as a percentage of total spend - the Director of Finance confirmed the Covid-19 spend is higher than some of our peers, partly due to double running costs of two sites.

RH highlighted the Trust are assuming a £5m saving in the current year on Covid-19 expenditure. The Director of Finance highlighted the efficiency challenge next year. The Director of Finance and Medical Director recently met with the Families and Specialist Services (FSS) Division to review Covid-19 spend and put in further challenge; acknowledging IPC guidance is changing on a regular basis.

OUTCOME: The Committee **NOTED** the CHFT Benchmarking Q3 Report 2021/22.

30/22 COMPANY SECRETARY'S BUSINESS

1. Annual Accounts Reporting and Process 2021/22

The Company Secretary presented the updated NHS accounts timetable for the annual report and accounts for 2021/22. The key dates to note were:

Financial Accounts

- Deadline for draft accounts (or agreement of balances) is 26 April 2022 (noon)
- Audited accounts submission is 22 June 2022 (noon)

Annual Report

- Annual Governance Statement – draft presented for review at Committee meeting on 26 April 2022
- Annual report submitted by 22 June 2022

The Committee will approve the annual report and accounts at its extra-ordinary meeting on 20 June 2022. A CHS Board meeting will be arranged to sign off the CHS element of the Group accounts prior to this meeting.

OUTCOME: The Committee **NOTED** the draft annual report and accounts timetable for 2021/22 and key dates and supported the request to the Board of Directors for delegation of authority to the Audit and Risk Committee to approve the 2021/22 Annual Report and Accounts.

2. Annual Governance Statement

As part of the annual reporting arrangements committee members were asked to review the draft 2021/22 annual governance statement which has been developed in line with the 2021/22 Foundation Trust Annual Reporting Manual guidance from NHS England / Improvement.

The number of internal audit reports referred to in the statement will be updated once the year end position is confirmed by Internal Audit.

The Trust is planning to declare that there have been no significant control issues during 2021/22, a similar position to that reported for 2020/21.

The draft statement has been reviewed by the Chief Executive and the Audit and Risk Committee Chair and been circulated to auditors for comment.

The final Annual Governance Statement will be formally approved as part of the sign off process for the 2021/22 Annual Report and Accounts.

The Company Secretary highlighted the reduction in days for internal audit will be reflected in the report.

RH agreed to share his comments with the Company Secretary.

OUTCOME: The Committee **NOTED** the draft Annual Governance Statement.

3. Review Code of Governance Compliance

The Company Secretary confirmed the Trust is compliant with all provisions of the code of governance. The enclosed paper details the Trust position relation to the application of the code and references key sources of evidence.

OUTCOME: The Committee **NOTED** the Trust's compliance with the Code of Governance.

4. Self-Effectiveness of Committee Action Plan

The Company Secretary presented the 2021/22 self-assessment summary of responses and associated action plan.

RH asked if the third-party assurances and payroll is covered in the internal audit plan. The Internal Audit Manager confirmed Leeds internal auditors are PWC who undertake their payroll function audit and the Internal Audit report is out in draft.

AN asked Committee members if there was a balance in terms of the Committee length of papers and if there were any views on how to improve this further. AN suggested closing this action and to keep it under review. RH acknowledged that progress has been made in terms of reviewing the main agenda and papers in the review room and he feels the Committee is in a reasonable place.
Action: Company Secretary to close the action relating to reducing the length of papers.

OUTCOME: The Committee **NOTED** the outcome of the Audit and Risk Committee self-effectiveness review for 2021/22 and the areas of continued improvement for 2022/23 in the action plan.

5. Declaration of Interest 2021/22 End of Year Update

Compliance at the end of the 2020/21 financial year for declarations by decision making staff was reported as 83% which has improved to 86% for the 2021/22 financial year.

The total number of decision makers for 2021/22 also increased by 96 staff. This shows the positive improvement on the compliance position for this year.

Weekly reminders to submit an annual declaration were sent to all decision makers during March 2022 and to increase compliance further, the Corporate Governance Manager contacted all 234 decision makers who had not yet made a declaration during in the last few days of the financial year. This improved the position with 76 decision making staff submitting a declaration by 31 March 2022.

OUTCOME: The Committee **NOTED** the improved compliance position on declarations by decision makers for the 2021/22 financial year as of 31 March 2022.

6. Review Audit and Risk Committee Attendance Register 2021/22

The Company Secretary presented the attendance register of the Audit and Risk Committee from 1 April 2021 to 31 March 2022 for any comment or corrections. The attendance of the Non-Executive Directors will be published in the annual report and accounts for 2021/22.

OUTCOME: The Committee **NOTED** the Audit and Risk Committee Attendance Register for 2021/22.

7. Audit and Risk Committee Workplan 2022

The Company Secretary presented the routine workplan for 2022 for approval.

AN reminded members due to timings the 20 June meeting will include a deep dive to avoid deferring any scheduled deep dives for the year.

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

31/22 SUMMARY REPORTS

A summary report of work undertaken since January 2022 was provided for the following sub-committees and these were made available in the review room:

- Risk Group – The Assistant Director of Quality and Safety formally thanked the team for their commitment and support in turning these key pieces of work around.
- Information Governance and Records Strategy Group – RH noted training compliance for IG (Information Governance) which is linked into the toolkit at 86% and asked if the 95% target will be reached. The Managing Director for Digital Health responded Helen McNae ran some advertising to promote awareness of the IG training. A further snapshot of the training position is expected this week to see if this improved compliance.
- Health and Safety Committee – no questions were raised.
- Data Quality Board – no questions were raised.
- CQC and Compliance Group – The Assistant Director of Quality and Safety confirmed there is a slightly different approach with focused Journey to Outstanding (J2O) reviews across the organisation over the last few weeks due to the likelihood of a CQC visit in the imminent future. Daily updates and meetings are taking place in an effort to get back to business as usual from Covid-19 and prepare for a CQC visit.

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

32/22 ANY OTHER BUSINESS

There was no other business.

33/22 MATTERS TO CASCADE TO BOARD OF DIRECTORS

- ***Acknowledge*** – Risk Management Process deep dive – encouraging progress has been made.

- ***Assurance*** – Approved the Internal Audit and Counter Fraud Plans for 2022/23. The Value for Money assessment undertaken by KPMG has not identified any significant risks. Approved the updated terms of reference for the Data Quality Board and Risk Group.
- ***Awareness*** – There are still 35 overdue Internal Audit recommendations which is a concern. Internal Audit have found it is taking much longer to complete some audits than in previous years.

34/22 DATE AND TIME OF THE NEXT MEETINGS

Monday 20 June 2022
Extra-ordinary meeting to sign-off the Annual Report and Accounts
1:00 – 2:30 pm
Microsoft Teams

Tuesday 26 July 2022
10:00 – 12:15 pm
Microsoft Teams

35/22 REVIEW OF MEETING

The meeting closed at approximately 12:01 pm.

Minutes of the Charitable Funds Committee meeting held on Wednesday 11 May 2022, 10.30am – 12.00am via Microsoft Teams

PRESENT

Philip Lewer (PL)	Chair
Gary Boothby (GB)	Director of Finance
David Birkenhead (DB)	Medical Director
Richard Hopkin (RH)	Non-Executive Director
Peter Wilkinson (PW)	Non-Executive Director
Adele Roach (AR)	BAME Representative

IN ATTENDANCE

Emma Kovaleski (EK)	Charity Manager
Carol Harrison (CH)	Charitable Funds Manager (Minutes)
Emily Overend (EO)	Marketing & Comms Assistant
Emma-Leigh Quinn (EQ)	Fundraising & Engagement Coordinator
Lyn Walsh (LW)	Finance Manager
Heather Lamont (HL)	CCLA
Antonia Cavalier (AC)	CCLA

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 Ellen Armistead, Jo Kitchen and Zoe Quarmby.

3. CCLA INVESTMENT PERFORMANCE REVIEW

A very comprehensive presentation was given by HL and AC from CCLA and its contents were NOTED. The paper had been circulated before the meeting so that the Committee was already aware of its contents. GB asked about Russian involvement in the portfolio and received clarification that there were no direct holdings in either Russia or Belarus. PL thanked them for the advice and guidance given to date.

4. MINUTES OF MEETING HELD ON 8 FEBRUARY 2022

The minutes of the meeting held on 8 February 2022 were approved as an accurate record but with one slight amendment. These amended minutes were emailed to Amber Fox to take to the next BOD.

5. ACTION LOG AND MATTERS ARISING
EK gave an update on the action log, in particular where due dates have been extended, and this was NOTED.

6. 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.
EK mentioned that some risk ratings had been reduced and that Public and Product Liability insurance was now in place.
RH asked that the reduced ratings and also target levels are reviewed again and GB/EK agreed to meet before the next meeting to review.

ACTION: GB/EK/RH meet to review risk ratings **– 11.05.22 – 1.**

7. ACCOUNTS 2021/22 OVERVIEW
CH presented this paper and its contents were NOTED. RH offered to look at these after ZQ/LW had checked them.

ACTION: RH to review once ZQ/LW's checks had been done - **11.05.22 – 2.**

8. FUNDRAISING UPDATE
EK gave the update as a slide presentation. She thanked her team for raising the Charity's profile via digital communications both internally and externally and for the increased community engagement.
The Tree of Memories will be unveiled on 23rd May.

As the next five agenda items were all related to General Purpose bids, PL asked about the Operations Sub Committee which was meant to look at these bids in advance of them being taken to this Committee. EK reported that, due to difficulties with quoracy, she had decided to suspend these meetings and the sub committee. The approvals process, together with other policies and procedures will be looked at once the Director of Corporate Affairs was in place.

9. BIDS FOR RATIFICATION
GB presented three bids which came via the cost pressures process and which have been approved outside of the meeting by some Executive Directors - ReSPECT, Childrens' Therapy equipment and BAME post extension for further year. GB asked that they are ratified. The Committee was happy to ratify. CH to inform successful bidders.

ACTION: CH to inform successful bidders **– 11.05.22 – 3.**

10. NEUROPHYSIOLOGY BIDS UPDATE
GB gave assurance that these two bids which had been approved in principle at the February meeting had now been approved via CMG/Dragon's Den and by EBME colleagues. The Committee was happy to approve. CH to inform C Roberts.

ACTION: CH to inform C Roberts – **11.05.22 – 4.**

11. BEREAVEMENT SUPPORT BID – update on BCAG's decision
GB confirmed that this bid which had previously been approved in principle by this Committee had now been through other governance and asked that it now be ratified. The Committee was happy to approve. CH to inform C Button.

ACTION: CH to inform C Button – **11.05.22 – 5.**

12. DRAGON'S DEN BIDS
GB explained the capital process that resulted in these bids being approved by an expert panel drawn from a multi disciplinary team (Ops/Risk/Associate Medical Directors). The Committee was happy with this assurance that they had been through a robust governance process and agreed to fund all six bids from the General Purpose fund. CH to inform successful bidders.

ACTION: CH to inform successful bidders **– 11.05.22 – 6.**

13. BID – JENNIFER CLARK
GB presented this bid but the Committee did not feel that it was an appropriate use of Charitable Funds and therefore was not approved.

ACTION: GB to inform J Clark – **11.05.22 - 7**

14. MINUTES OF STAFF LOTTERY COMMITTEE MEETING 15 MARCH 2022
The paper is for information only and its contents were NOTED.

15. ANY OTHER BUSINESS
EK presented a late bid for a Wellbeing Choir with support from DB. The Committee was happy to approve this. EK will inform the bidder and ask for information around time frames, impacts, KPIs, etc.

ACTION: EK to inform the bidder and get further information - **11.05.22 – 8.**

PL confirmed that this is his last meeting and the Committee expressed their thanks for all his excellent work.
CH asked that she meets with GB to confirm an amount to transfer to the General Purpose fund from the General Reserve fund, due to the bids that have been approved and to be mindful of the cashflow situation moving forwards.

DATE AND TIME OF NEXT MEETING:
Tuesday, 9 August 2022, 10.30 – 12am, via Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 3rd May 2022, 11.00am – 13.00pm Via Microsoft Teams

PRESENT

Richard Hopkin	Non-Executive Director (Chair)
Gary Boothby	Executive Director of Finance
Philip Lewer	Trust Chair
Anna Basford	Director of Transformation and Partnerships
Peter Wilkinson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Peter Keogh	Assistant Director of Performance
Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Robert Markless	Public Elected Governor
Brian Moore	Public Elected Governor
Stuart Baron	Associate Director of Finance - CHS
Jim Rea	Managing Director Digital Health - THIS
Jane Peacock	General Manger - Surgery
Isaac Dziya	Public Elected Governor

ITEM

068/22 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

069/22 APOLOGIES FOR ABSENCE

Apologies were received from Jo Fawcus

070/22 DECLARATIONS OF INTEREST

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

071/22 MINUTES OF THE MEETING HELD 4th April 2022

The Minutes of the last meeting were APPROVED as an accurate record.

072/22 MATTERS ARISING

039/22 – New Access Committee TOR and reports to be presented to Committee - JF

073/22 ACTION LOG

The Action Log was reviewed as follows:

138/20 – Stroke Deep Dive: comparison of CHFT mortality rates to regional and national rates still to be circulated – JF/PK – The feedback was that there is no current data available. Is there a national standard that CHFT can monitor themselves against?
ACTION: PK to follow up outside of the meeting

131/21 – Neck of Femur (NofF) Performance: A short presentation was provided by JP with a more in-depth report planned for the August meeting once the new consultant has been in post for six months.

The last presentation was in November 2021. Since then a consultant has been employed specifically for trauma on a 12 month contract. KPI's have been added to the business case for that consultant. The 36 hour from admission to theatre target is set at 85%. This has not been achieved by CHFT over the last twelve months. Covid is expected to have impacted on this. This picture is reflected nationally. There is a KPI relating to a reduction to 12 days length of stay but the CHFT average number of days has been around 15 to 17 with an increase in February to 19.2 days. In the last two months there has been a substantial increase in the number of patients coming into hospital with a fractured neck of femur. The average length of stay nationally is 14.7 days. The treatment pathway has been reviewed and the service users have been asked for their experiences as well as nursing homes and relatives. The plan is to update the patient pathway so that it is suitable for all. Mortality rates have been steady except for a spike in December. Many patients were too unwell to go to theatre. Nationally the mortality rate across the country is running at 7.6% and with the CHFT figure over a 12 month period running at an average of 6.3%. A deep dive has taken place and found nothing untoward. There was no correlation between a patient reaching theatre within 36 hours and the mortality rates. It was not an organisational issue but as a result of having more poorly patients. The arrival of the new consultant is allowing measures to be put in place to improve the performance. These will be reported on at the August meeting. CHFT has been linking up with other Trusts around the country and sharing learning on what works well for each Trust.
ACTION: Numbers to be included in future reports as well as percentage variances. JP

025/22 – Capital Profile: This action can now be closed.

FINANCE & PERFORMANCE

074/22 MONTH 12 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

The risks for 2022/23 will be updated and brought to the next meeting.
The financialposition at year end was better than break even with a £40k surplus (based on the regulatory view of performance, the annual accounts figure will differ for technical accounting adjustments which are excluded from the NHSE/I judgement). This did rely heavily on non-recurrent income to support this position, to cover the shortfall in CIP as well as additional pressures. Achieving this position has been challenging with the Trust experiencing a number of significant financial pressures, in particular the growing cost of temporary staffing (enhanced bank rates and high cost agency) the ongoing pressure on capacity due to Covid 19 and the cost of Recovery. H2 also included a significant efficiency requirement of £6.7m, of which only £3.54m has been delivered. However, the Trust successfully bid for additional Elective Recovery Funding in support of schemes to increase capacity, and also secured some additional non-recurrent funding allocations from both local Commissioners and the Integrated Care System (ICS), which between them have mitigated these additional cost pressures.

CHFT achieved a Use of Resources score of 2 for the year.(1 is the highest score).

Cash balance of £54.65m in the bank at the end of the year but this is expected to reduce in the new year as capital payment commitments are processed.

Aged debt has been reduced by £1m over the last year.

A better payment practice score of 94% was achieved against a target of 95%.

The overall ICS position at the end of the year was breakeven with a lot of organisations who also broke even and some who were in a better position.

The Committee **RECEIVED** the Month 12 Finance report

075/22 EFFECTIVE USE OF RESOURCES GROUP (ERG) / EFFICIENCY TARGETS

At the last meeting time was spent reviewing the latest updates of the plan preparing it for submission to Board on Thursday. Since the last submission the planned deficit has improved from £23.1m to £20.1m. There has been a deep dive from the ICS looking at some of the data around planning and also a deep dive by Rob Webster, CEO Designate of the ICS and the ICS team who challenged CHFT to identify improvements.
There is still a further challenge but as of this moment there has been no agreement to commit to anything further. There is still a reliance on delivering a £20m CIP programme and the £5m Covid exit costs reduction. Overall, a £25m efficiency which is around 5%. There remains a £20m deficit in the plan that was submitted.

The overall ICS plan that was submitted is for a £72m deficit next year. £20m of this is attributed to CHFT, with deficits from other organisations within the Place which suggests that this local area is more challenged than others within the region. The Yorkshire Ambulance Service (YAS) has several challenges from both a service performance and financial point of view. Currently this equates to a £30m challenge for next year and as they are hosted by West Yorkshire it is a key factor in the overall position for the region.

While the final plan for the ICS has been submitted and shows a deficit, this remains a work in progress.

Further efficiency schemes for CHFT are to be agreed in today's ERG meeting that aim to bridge the gap between the £18.5m already identified and the £20m efficiency target. These schemes will go through thorough governance before being implemented.

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

077/22 BBRAUN DECONTAMINATION CONTRACT

BBraun provides the decontamination service for the Trust and other trusts across West Yorkshire. BBraun were unwilling to extend the existing contract beyond the break clause date without a change in the commercial value of the contract. BBraun proposed an 18% uplift to the contract. Through negation, partners have proposed the following:

- A one-off non-recurrent payment in 2022/23, with CHFT's share of this being £192k; and
- A recurrent price increase of 13.5% per annum, equivalent to £250k per annum for CHFT for the remaining 4 years.

The total cost of the proposed contractual change is £1.2m.

A price increase was anticipated as part of the annual planning cycle for 2022/23 however there is a non-recurrent cost pressure in 2022/23 of £112k based on this proposal.

To obtain an alternative supplier would take approximately 2-3 years and it will require some investment and involvement from partners across the ICS and WYAAT.

The Committee **NOTED** the change to the BBraun decontamination contract.

078/22 INTEGRATED PERFORMANCE REVIEW – MARCH 2022

The Assistant Director of Performance reported the Trust's overall performance score for March 2022 was 64% which is an improvement on February's position of 62%. There was however a 'never event' in March. Hospital Standardised Mortality Ratio (HSMR) went above 100 as expected but all cancer targets were met.

Safe domain is now in AMBER following the never event.

Caring domain remains Amber but two of the friends and family areas are now Green but performance in complaints responses is still a challenge. Dementia screening has improved slightly to 25% and plans are in place to improve this further.

Effective domain remains Amber as Hospital Standardised Mortality Ratio (HSMR) has risen above 100. Challenges to the availability of specialist palliative care staffing led to patients not being captured through coding as being on a palliative case pathway. The Medical Director is looking at a way to resolve this. Neck of Femur is still a challenge at 64%.

Responsive domain remains amber with all key cancer targets achieved for March which is an excellent achievement. Stroke indicators alongside the underperformance in the main planned access indicators and ED remain a challenge moving forward.

Workforce remains amber and there is a peak in the 12-month running total for both long-term and short-term sickness with an increase in Covid related sickness in March when compared to February though not at the same level seen in January. Return to Work Interviews have improved in month.

Finance domain remains Amber and the Use of Resources indicator has turned green.

Health Inequalities group met last week and updated the gap between average wait times for both BAME patients and non BAME patients and IMD1 against IMD9 and IMD10.(IMD 1 being the most deprived area). In March last year the difference in BAME was 7.2 weeks longer. As of April, the difference in the average wait time is down to 0.2 weeks. For P2 patients for IMD1 and IMD2 there is only a difference of 0.4 weeks compared to a number of weeks last year. For P2, P3 and P4's combined, BAME and Non BAME patients were compared. In May last year these combined groups of patients were waiting an extra 5.1 weeks but in April this year the difference was down to 2 weeks.

As a result of such significant progress having been made CHFT has been asked to talk about our success regionally and nationally, as other organisations are not seeing the same improvements. We have been asked to give a one-hour presentation next week to the CQC for their health and equalities week.

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

079/22 RECOVERY UPDATE

The Assistant Director of Performance presented a recovery update as follows:

P2's – It was planned that the P2's would reach zero by the end of March 2022. The numbers have reduced and the figure at the end of the year was around the 100 mark. Surgery in particular are confident that they will reduce those numbers soon.

P3's – Due to the reduction in 104 week waits the next two to three months will allow focus on the P3's and improvement is expected by the end of June.

P4's – Any available capacity is being used to treat P4's.

Open Pathways – These are reducing slowly.

Inpatients / Day Cases – Targets have been set for 2022/23 and the intention is to reduce all 'longer waiters' numbers down to zero by February 2023, with the exception of ENT which is ahead of external targets.

78 week waits – again the intention is for these to reach zero by the end of March 2023.

104 week waits – These have suddenly reduced nationally as it is two years since the covid pandemic started. This was expected. The numbers at CHFT are showing an excellent performance compared to other organisations within West Yorkshire. We do have waits where the patient has specifically chosen to wait. These are being man marked.

Diagnostics – In Neurophysiology and ECHO new trajectories have been created. These have a target date of May for reaching lower numbers. The aim was to achieve zero in Neurophysiology by May 2022. This is slightly off track. ECHO is scheduled to be back on track by the end of August.

MRI – The numbers have deteriorated over the last few months due to staffing, the installation of the new scanners, and problems with the third party provider. Now on target to have cleared the backlog by June.

ASI's and Follow ups – Plan to reduce to pre Covid numbers. ENT to reduce their numbers by 50%. ASI's over 22 week plans to reduce back to zero.

Follow up Trends – Trajectories for each speciality will be added to the graphs to show how the numbers are expected to reduce. In the plans for 22/23 nationally, follow ups are expected to reduce however, CHFT to date has been unable to do this and reduce the follow up backlog. There are almost 80,000 patients on the follow up wait list so still plenty of work to be done, but positive progress has been made on the key areas of focus.

As the new Access Group gets underway more detail will become available.

Achieving the 104% target (against 2019/20 figures) will be crucial for the financial position in 2022/23 as spending will be committed with the expectation this will be achieved, and the funding targets for the ERF are met.

The Committee **NOTED** and **RECEIVED** the Recovery update for March 2022.

080/22 ANNUAL REVIEW

The written annual review of this Committee was submitted as part of the papers.

Under the business and commercial development section for future reports, recognise that this Committee also reviews the strategies for THIS and HPS.
The digital strategy was also received by this Committee.

063/22 DRAFT MINUTES FROM SUB-COMMITTEES

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

- THIS Executive Board – February 2022

- Capital Management Group – February 2022

The Urgent Emergency Care Board has been stood down and is to be replaced with the Urgent and Emergency Care Delivery Group from April.

ACTION: Brief overview **/** Terms of reference for the Urgent and Emergency Care Delivery Group and Access Group to be provided at the next meeting. Minutes to be sent to Rochelle - JF

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

064/22 WORKPLAN – 2022/23

The workplan for 2022/23 was reviewed.

ACTIONS:
Surgery / Theatre deep dive and Stroke deep dive to be separated so they are not reported at the same meeting.

RH and RLS to arrange with Suzanne Dunkley how often the workforce deep dive needs to come to this meeting.

065/22 ANY OTHER BUSINESS

None noted.

066/22 MATTERS TO CASCADE TO BOARD

Key points to be covered in Chair's Highlights Report to Board.

067/22 REVIEW OF MEETING

No specific review carried out.

DATE AND TIME OF NEXT MEETING:
Monday 7th June 2022, 13:00 – 15:00, MS Teams

Calderdale and Huddersfield NHS Foundation Trust

Minutes of the Finance & Performance Committee held on Tuesday 7th June 2022, 13.00am – 15.00pm Via Microsoft Teams

PRESENT

Richard Hopkin	Non-Executive Director (Chair)
Anna Basford	Director of Transformation and Partnerships (Until 2pm)
Peter Wilkinson	Non-Executive Director
Jo Fawcus	Chief Operating Officer

IN ATTENDANCE

Kirsty Archer	Deputy Director of Finance
Andrea McCourt	Company Secretary
Rochelle Scargill	PA to Director of Finance (Minutes)
Robert Markless	Public Elected Governor
Brian Moore	Public Elected Governor
Nigel Broadbent	Non-Executive Director

ITEM

086/22 WELCOME AND INTRODUCTIONS

The Chair welcomed attendees to the meeting.

087/22 APOLOGIES FOR ABSENCE

Apologies were received from Gary Boothby, Peter Keogh and Stuart Baron

088/22 DECLARATIONS OF INTEREST

There were no declarations of interest noted.

089/22 ONE CULTURE OF CARE (OCOC)

This is a new agenda item that is to be included on the agenda for every Trust meeting. This will be a standing item but if attendees have any specific OCOC issues to raise they can be raised at any time.

The Trust is refreshing the People's strategy and the four pillars are to be replaced with four values.

RH has spoken to Suzanne Dunkley and it has been agreed she will attend this meeting quarterly.

ACTION: Rochelle to arrange dates with Suzanne.

090/22 MINUTES OF THE MEETING HELD 3rd May 2022

The Minutes of the last meeting were APPROVED as an accurate record.

091/22 MATTERS ARISING

Data around stroke mortality rates benchmarking has still not been received by RM.

ACTION: JF and Peter Keogh to follow up. RH to follow up at next meeting in the absence of RM.

092/22 ACTION LOG

The Action Log was reviewed as follows:

063/22: No ToR's or minutes have been received from the new Urgent and Emergency Care meeting.

ACTION: To be circulated outside of this meeting. JF to follow up.

FINANCE & PERFORMANCE

093/22 MONTH 1 FINANCE REPORT (Including High Level Risks and Efficiency Performance)

A new page has been added to the report this month which shows the Integrated Care System (ICS) and PLACE financial position.

All financial plans for all organisations are due to change as national funding has been announced. An extra £1.5b to cover inflationary pressures, but how it will be distributed is still to be confirmed. The locally allocated funding will go to both CHFT and the local CCGs. The ICS will expect to see an improvement in overall financial positions.

Year to Date Summary

Year to date the Trust is reporting a £3.03m deficit, a £0.11m favourable variance from plan. The Trust has submitted a plan to deliver a £20.1m deficit for the year. Additional funding for inflationary pressures has since been announced, which is likely to improve this position to some extent.

- In Month 1 the Trust has incurred costs relating to Covid-19 of £1.80m, £0.70m higher than planned. Covid-19 activity was higher than planned, driving additional staffing costs and consumables, with some extra capacity opened that was planned to be closed by the start of the new financial year.
- Year to date the Trust has delivered efficiency savings of £0.82m as planned.
- Agency expenditure year to date is £0.87m, £0.140m higher than the NHS Improvement Agency expenditure ceiling (planned value yet to be confirmed).
- Total planned inpatient activity was only 94% of the activity planned for April.

Key Variances

- Income is £1.18m below the planned year to date. This includes £0.72m of planned Elective Recovery Funding (ERF), that has not been assumed due to the activity levels delivered in Month 1 being below plan.
- Pay costs are £1.15m below the planned level year to date. The underspend is primarily linked to vacancies, particularly in Community and FSS Divisions and lower than planned Recovery costs. The majority of pay related efficiency plans are profiled to start later in the year, including those relating to the exit from Covid-19 costs and this likely to put greater pressure on pay budgets as the year progresses.
- Non-pay operating expenditure is at the planned level.

Forecast

The Trust is forecasting to deliver the planned £20.1m deficit. This assumes delivery of a challenging £20m efficiency target.

High Level Risks

The financial risks for 2022/23 have been reviewed. Capital and cash are proposed to remain as they were based on the healthy cash position going into the year. The risk around Income and Expenditure plan has been amended and a risk score of 20 has been proposed at this point in the new financial year. The associated narrative describes the challenges that reflects. The thresholds around securing ERF have not yet been set nor have the mechanisms as to how the funding will be secured. The scale of the CIP requirement is challenging.

It was noted that two thirds of efficiency savings are non-recurrent and queried whether there a risk between the end of the non-recurrent savings and reconfiguration taking place? Yes there are risks. The focus of the ERG meeting going forward is the maintenance of those savings identified to make sure they are delivered, and to work on identifying savings for 2023/24. Due to Covid and other pressures the timeline for identifying savings for this year was very tight.

In order to achieve ERF, 104% recovery target must be achieved which is based on value not volume and is cumulative across the year.

It was noted that the information around recovery was not easy to find within the report. Is it possible that the ICS can be monitored as whole as to how they are performing against the 104%. CHFT has requested to see this data once it has all been collated but there will be a time lag in this on a monthly basis.

Agency spend is running higher than expected. Covid affected capacity pressure. ERG is focussing on reducing this. This is more of a cost avoidance exercise rather than efficiency as high levels of agency spend was not planned for. The agency threshold has not been received from NHSEI. Agency meetings are in diaries.

ACTION: An additional comparator relating to 104% is to be added and this element to be made more prominent in the reporting.

The Committee **RECEIVED** the Month 1 Finance report and APPROVED the proposed risk ratings.

094/22 EFFECTIVE USE OF RESOURCES GROUP (ERG) / EFFICIENCY TARGETS

The ERG headlines were included in the paper. As the papers were issued £18.8m of savings had been identified. The full £20m has now been identified inclusive of further covid exit costs. Withdrawing additional layers of staffing in ED. CHFT is planning to receive specific income to support a development, which we had originally been expected to fund internally.

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

095/22 INTEGRATED PERFORMANCE REVIEW – MARCH 2022

The Chief Operating Officer reported the Trust's overall performance score for April 2022 was 68% which is an improvement on March's position of 64%. This was mainly due to changes in the workforce domain.

Safe domain is now GREEN again.

Caring domain remains Amber. Two of the friends and family areas are now Green but performance in complaints is at its lowest level in terms of those closed within the target timeframe. Dementia screening has fallen again in month following a slight improvement last month.

Effective domain remains Amber although Neck of Femur has surpassed 70% for the first time since May 2021 but is still below the 85% target.

Responsive domain remains Amber with all key cancer targets again achieved for April. Stroke indicators alongside the underperformance in the main planned access indicators and ED remain a challenge moving forward.

Workforce remains Amber and there is a peak in the 12-month running total for both long-term and short-term non covid related sickness. Return to Work Interviews have reduced in month.

Finance domain remains Amber.

Note that the Jubilee celebrations could have an impact in the next couple of weeks as people gathered to celebrate.

Cancer performance all targets were met. This is becoming more and more challenging due to workforce.

Stroke demand is outstripping the available capacity.

Workforce is still being affected by short term covid sickness and isolations.

JF and Peter Keogh are currently working on changing the IPR which is a work in progress. Going forward the data will be based more on the SPC analysis. Looking at each chart for actions and mitigations. Health and Equality will become clearer.

ACTION: Full IPR not in pack. Include Health inequality new info re learning disabilities page going forward as mentioned on cover sheet– PK

ACTION: Skill Mix shows as Red each month In Theatres etc. lots of experienced staff have left. JF to get more details from SD and Lindsay

Delayed transfer of care has changed. CHFT reached 69 just before the bank holiday as of today the figure is 74. A daily meeting with system leads and the discharge lead takes place to focus on discharge on the wards. Electronic white boards being piloted on some wards are helping with focus on facts and not opinions.

Complaint response times have continued to deteriorate. This is being picked up at the performance review meetings. Each division has key actions how to improve complaint response times. There is a challenge with complex complaints that cover multiple divisions. Aim to improve over the next 3 months.

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

096/22 RECOVERY UPDATE

The Chief Operating Officer presented the recovery update. The number of slides included in the pack increased and a lot of detail added.

104 week – Colleagues are micromanaging a small group of patients through their treatment. The number still waiting is now reduced to 14. A Daily meeting around 104 weeks takes place, and we are on track to clear the position by July. Worth noting that other organisations are not in same positive position as CHFT. CHFT has been asked to help other organisations.

78 weeks – started to reduce. Divisional breakdowns are included in the papers highlighting some specialties where there are challenges. ENT was a challenge but now reducing as are the Appointment Slot Issues (ASIs). Progress is being made.

52 weeks – The trajectory aims to reduce to zero by Feb 23. This is a CHFT created target which is stricter that any national targets. The number of theatre lists is expected to increase over Summer which will impact the 52 week waits positively.

ASI's – Have been broken down by division and by speciality. The CCG's have been very supportive and have commissioned extra capacity.

Follow up backlog now included in pack.

Diagnostics are on track. MRI are aiming to clear the backlog by the end of June. ECHO and Neurophysiology are showing signs of improvement still highlighted. External companies are providing support.

P2/3/4's may not be included in the paper going forward. An audit and review of P3's will take place at the new Access and Urgent care meeting.

Work is ongoing to produce a dashboard. This should be ready completed in time for the June meeting.

The Committee **NOTED** and **RECEIVED** the Recovery update for March 2022.

097/22 Board Assurance Framework (BAF)

The Company Secretary presented the first BAF update of this year and the full BAF framework will go to board in July. Included within the papers are the six risks that this committee have responsibility and oversight for. No new risks have been added in this update and there is only one risk where the score has changed. The risk is around commercial growth and has been increased from 6 to 9 with the rationale in the paper. The risk is around Huddersfield Pharmacy Specials (HPS) and the loss of a customer and some uncertainty around future access to pricing.

The HPS wholesale strategy is being reviewed.

It was felt by the committee that the risks and their scores reflect the challenging financial position we are in.

RISKS Approved to take to board.

The Committee **APPROVED** the BAF risks to be taken to board.

098/22 TERMS OF REFERENCE FOR THIS COMMITTEE

The ToR's have been brought to this meeting to update membership as the Chief Executive no longer attends but the new Director of Corporate Affairs will attend. (As per email 5th May 2022.)

Hospital Pharmacy Specials to be corrected to Huddersfield Pharmacy Specials.

Section 5.2 will be updated to two Governor representatives invited to the meeting instead of one.

ACTION: The paper for the next committee meeting to be sent to Vicky Pickles, Director of Corporate Affairs.

099/22 TERMS OF REFERENCE FOR ACCESS COMMITTEE

The aim of the meeting is to oversee recovery and make sure there is a governance architecture. Different boards and forums that existed previously are now under one umbrella. Decisions will be made around remedial actions. Meet monthly with key attendees. Look at wating lists and national directives.

The ToR's submitted were in draft form and changes had been discussed since the papers were submitted.

The Vice Chair will be the Surgical Director of Operations.

This will be a subgroup of this committee and will report in accordingly.

The Committee **APPROVED** the Terms of Reference for the Access Committee.

100/22 DRAFT MINUTES FROM SUB-COMMITTEES

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

- Cash Committee
- Business Case Approval Group
- CHFT / SPC Quarterly
- THIS Executive Board – April 2022
- Capital Management Group – May 2022

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

101/22 WORKPLAN – 2022/23

The workplan for 2022/23 was reviewed.

The commercial strategy for HPS has been deferred until the next meeting.

The Committee **APPROVED** the Workplan for 2022/23

102/22 ANY OTHER BUSINESS

RH enquired if the year end audit was going to plan. KA stated that the feedback received so far has not highlighted anything unexpected.

103/22 MATTERS TO CASCADE TO BOARD

Key points to be covered in Chair's Highlights Report to Board.

104/22 REVIEW OF MEETING

No specific review carried out.

DATE AND TIME OF NEXT MEETING:
Monday 7th June 2022, 13:00 – 15:00, MS Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Wednesday, 20 April 2022

STANDING ITEMS

56/22 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DB)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Lisa Cook **(LC)**	Head of Risk and Compliance
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jo Fawcus **(JF)**	Chief Operational Officer
Karen Heaton **(KH)**	Non-Executive Director
Nicola Seanor **(NS)**	Associate Non-Executive Director
Kim Smith **(KS)**	Assistant Director for Quality and Safety
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lucy Walker **(LW)**	Quality Manager for CCGs
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Anita Hill **(AH)**	Medication Safety Officer **(item 63/22)**
Sarah Mather **(SM)**	Acting Head of Legal Services **(item 65/22)**

57/22 APOLOGIES

Jo Kitchen **(JK)**	Staff Elected Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Dr Cornelle Parker **(CP)**	Deputy Medical Director

58/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

59/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Monday, 21 March 2022 were approved as a correct record. The action log can be found at the end of these minutes.

60/22 MATTER ARISING: DETERIORATING PATIENT UPDATE

Lisa Cook presented the above report, as circulated at appendix C, providing the Committee with an update regarding ongoing work related to deteriorating patients, with input for multiple teams and challenges with access to beds.

KH stated that consistent improvements are needed to ensure that the work being done has the impact required and can be sustained, therefore an update at a reasonable timescale at the Committee would be welcomed.

DS commented on the significant reductions of incidents from 62% to 15%, as well as the suggested case note review to evidence that recommendations have been embedded and asked when this is likely to be undertaken. **LC** stated that it could be done in the next few months and is similar to work already undertaken with patient safety alerts and other themes and trends and fed into the audit programme. It was also noted that this could also link into another case note review around vulnerable patients who attended the emergency department and be done as a joint piece of work and into the audit programme. **KS** agreed to the joint piece of work, as there will be shared learning and actions.

LC was thanked for the update, with a further update requested in three months' time.

OUTCOME: The Quality Committee noted the report.

SAFE

61/22 Q4 INFECTION CONTROL PREVENTION AND CONTROL REPORT

David Birkenhead presented the report, as circulated at appendix D, stating that the report is also the year-end report.

The objective for Clostridium difficile (C. diff) was breached for 2021/22. CHFT was not unique, as there is an increase in C. diff across all acute sector organisations, which possibly relates to COVID-19, an increased acuity of hospital admissions, increased admissions of the elderly and probably broad spectrum antibiotic usage, all of which will contribute to the increase in cases.

There were no cases of Methicillin-resistant staphylococcus aureus (MRSA) bacteraemia through the last year, and also fewer Escherichia coli (E. coli) bacteraemia than in previous years.

Overall, CHFT infection prevention and control metrics performed well compared to peer trusts. COVID-19 continued to dominate over the last year and over the last quarter, with high rates of Omicron within the organisation. With Omicron being more transmissible than previous strains of COVID, it is not surprising that there have been a number of outbreaks, with seven open outbreaks at this point in time. Many outbreaks have not been avoidable, due to patients who have been identified with COVID after a number of days after being admitted and have been asymptomatic. Other outbreaks have included norovirus, with three outbreaks occurring during quarter 4 on the Huddersfield site.

Guidance continues to be refreshed and revised around testing and visiting. Revised guidance around general infection prevention and control (IPC) measures are being reviewed and recommendations will be made, or not, for their implementation. COVID-19 has affected a number of patients, and had a significant impact on staffing, with a number of colleagues away from the organisation with COVID, which presents additional challenges.

FFP 3 mask testing is being revised to ensure resilience for future waves of COVID, and a number of COVID assurance audits which took place are included in the report.

GC asked about non-compliance from the general public. **DB** stated that the vast majority of the public are compliant with mask guidance, however, there have been a few people who may inadvertently forget to wear a mask. Where this has been identified, colleagues are encouraged to remind patients and their visitors they need to wear masks. That guidance remains in place and will not change.

DB acknowledged the work of the IPC team over the last two or three years for their ongoing support, which has been, and continues to be a challenging time.

DB was thanked for the update.

OUTCOME: The Committee noted the report.

62/22 Q4 TRUST PATIENT SAFETY AND QUALITY BOARD REPORT

Kim Smith presented highlights from the report, as circulated at appendix E.

In relation to the Medication Safety and Compliance Group and findings from the Journey 2 Outstanding (J2O) visits, **EA** stated that attendance at the Group is crucial. In relation to issues

around medical device training, a pragmatic approach may be needed with the training. **KS** stated that blended learning may be the new approach to different types of training.

KH stated that there are a number of critical issues which need addressing, and some improvement and commitment is needed.

DS mentioned the good progress made in terms of patient safety alerts, and the one outstanding alert in relation to the steroid emergency card. It was asked if the alert would be closed soon. **KS** stated that it will be closed down, as the immediate actions and learning will be addressed. The follow-up actions in relation to audits and processes will continue to be monitored. **LC** confirmed that the alert has now been closed, however, there are some robust actions and ongoing work which will continue.

KS was thanked for the update.

OUTCOME: The Committee noted the report.

63/22 Q4 MEDICAL GASES GROUP REPORT

Anita Hill was in attendance to present the report as circulated at appendix F.

In relation to the audit process and the number of never events where people were connected to air instead of oxygen, **EA** asked when an audit was last carried out and if the Group is cited on that. **AH** stated that the audit has been discussed and needs to be identified on the risk register on how it will be managed. It is currently part of the J2O audits that are being undertaken. **EA** stated that an urgent piece of work is now required and would be worth carrying out a quick audit, independent of the divisions. **ES** stated that an audit has been carried out at HRI and one now needs to be done at Calderdale. **AH** agreed to take the action away.

AH was thanked for the update.

OUTCOME: The Committee noted the report.

64/22 HIGH LEVEL RISK REGISTER

Lisa Cook presented the report as circulated at appendix G.

There is an ongoing piece of work around the risk registers, and key to that is the role and function of the Risk Group. The terms of reference have been reviewed, however, there is still some work to do in terms of getting the meeting to work effectively. There is good engagement in the Group, and one of the key things being done at the moment is looking at cross-divisional risks and how they feed into any trustwide risks. There is also ongoing work with the divisions to link risk descriptors to measurable outcomes. This will support a clear link with risk scores and the effectiveness of mitigating actions as well as the impact of any gaps.

The number of high risks across the organisation have reduced, and the new risks proposed and accepted by the Risk Group require some further information and detail. There were four risks with a reduced score.

KS added that some focused work around implementing lessons learned as a result of serious incident panels will begin next week.

LC was thanked for the update.

OUTCOME: The Committee noted the report.

WELL LED

65/22 Q4 LEGAL SERVICES REPORT

Sarah Mather was in attendance to present the report as circulated at appendix H.

In terms of claims, **KH** asked how other Trusts compare to CHFT. Given that there are two hospital sites, **SM** stated that the numbers are fairly low in comparison.

DS commented on the Prevention of Future Deaths report, and **SM** stated that the Trust last received a report in 2019, which is encouraging. In relation to this particular case, **SM** stated that the serious incident report was not as robust as it could have been, therefore, measures have been put in place in terms of strategy meetings and risk profiling those inquests to ensure plans in place to mitigate prior to getting to an inquest.

EA stated that the next step would be to review any Regulation 28 cases or any complex coroners cases to check that there has been some learning.

SM was thanked for the thorough report.

OUTCOME: The Committee noted the report.

66/22 COMMITTEE'S SELF-ASSESSMENT 2021-2022 FORM

The Chair noted that the Committee's annual self-assessment is now due, and the form will be circulated for a response by Friday, 6 May 2022.

RESPONSIVE

67/22 QUALITY REPORT

Kim Smith presented the report as circulated at appendix I.

GC commented on the dementia screening which needs to be addressed, as well as the quality account priorities which went to the Council of Governors, where there was a debate as to what was going to be agreed going forward. It was agreed that they would continue, however, it seems that progress is not being made. **GC** was seeking stronger reassurance that more progress will be made in those areas. **KS** stated that the focus this year is that each quality priority will have three key performance indicators which will be clearly measured with clear outcomes. Work has been taking place on the governance arrangements.

In terms of dementia screening and the low levels against compliance, **DB** stated that this is a challenge, and may remain so, as CHFT is the only Trust in West Yorkshire where this is a medical activity rather than nursing, and work is ongoing to try to resolve the issues.

DS shared concerns about the three deaths from falls, and the comprehensive list of actions that are being taken. In terms of the three deaths, it was asked if there were any themes. **KS** stated that there were no themes, due to the patients being frail. The Falls Collaborative are looking at the risk assessment and ensuring they are monitored. It is also part of the safety huddles and J2O processes for assurance. **DB** also mentioned that there is some work which is reported into the Clinical Outcomes Group, however, there was not an obvious trend in relation to the falls. The frailty of patients and staffing levels on some wards as a result of COVID absences was noted as potential risk simulation to falls management.

OUTCOME: The Quality Committee noted the report.

68/22 INTEGRATED PERFORMANCE REPORT

Jo Fawcus presented the integrated performance report at appendix J, highlighting key points.

The SAFE domain is still the Trust's only area still green. The CARING domain remains amber although four of the five Friends and Family Test areas are now amber and performance in Complaints has dipped again. Dementia screening is now at its lowest level this financial year at just below 20%. The EFFECTIVE domain remains amber and Summary Hospital-level Mortality Indicator and Hospital Standardised Mortality Ratio values continue to increase. Fractured Neck of Femur has shown a small improvement at 67%. The RESPONSIVE domain is now amber with improvements in 31-day cancer performance. Stroke indicators alongside the underperformance in the main planned access indicators and ED are the main challenges. WORKFORCE remains amber and we are still seeing a peak in the 12-month running total for both long-term and short-term sickness. Return to Work Interviews are still at 60%. FINANCE domain remains amber.

The number of transfer of care patients have managed to get below 100 for the first time, and another stroke summit around transfer of care delays took place to try to move that number as it will impact on falls and other indicators.

DS asked whether the cancer target performance is sustainable going forward. **JF** stated that the 62 day standard has been achieved consistently however, the move to the new 28 day faster diagnostic will present another burden in terms of how the teams work. The first cancer delivery group meeting took place in April, which is a monthly meeting, and each month, a deep dive into each tumour site will be done to see where the problems are and what support is required, as it is not sustainable if it does not keep evolving.

OUTCOME: **JF** was thanked for the update and the Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

69/22 MEDICINES MANAGEMENT COMMITTEE MINUTES

A copy of the Medicines Management Committee minutes was available at appendix K for information.

OUTCOME: The Committee received and noted the minutes.

70/22 CLINICAL OUTCOMES GROUP MINUTES

A copy of the Clinical Outcomes Group minutes was available at appendix L for information.

OUTCOME: The Committee received and noted the minutes.

71/22 ANY OTHER BUSINESS

Journey 2 Outstanding (J2O) Immediate Learning

KS briefly highlighted the set of slides circulated at appendix M, from some work done last week, and the actions which have been progressed.

CQC Preparation

EA stated that the CQC are expected in the emergency department at some stage, and it is assumed that they may want to go into other areas. Some focussed Journey 2 Outstanding visits have taken place and been helpful in getting to a place of readiness. Enough findings and themes from the J2O visits will provide a picture of what is needed in terms of leadership assurance going forward. A paper will be taken to the Executive Board making expectations of the organisation very clear. It was stated that this is not only about CQC preparation;

however, it is about getting back on track, and no doubt COVID-19 has had an impact on our quality metrics, and this is a good opportunity to get back on track.

There is an immediate urgent action to ensure the emergency department and acute floors are where they need to be, then an assurance framework will be created, and running alongside that will be some well-led preparation. There will also be a piece of work around maternity, much of which is covered in the Ockenden action plan. The emergency department are in a strong position and an update into this Committee around some of that preparation will be welcomed.

DS asked that the expectations paper is also shared with the Committee.

72/22 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- The quarter 4 Infection Prevention and Control report
- The quarter 4 Trust Patient Safety and Quality Board report, and encouragingly, in a good position with the patients and safety alerts
- The quarter 4 legal services report, and receipt of a Regulation 28 report, however, in a position to provide assurance that the response to the coroner will give an appropriate update on the changes put in place.
- The Integrated Performance Report.

73/22 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix N for information.

POST MEETING REVIEW

74/22 REVIEW OF MEETING

The meeting overran.

NEXT MEETING

Monday, 16 May 2022	3:30 – 5:00 pm	Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE

Monday, 16 May 2022

STANDING ITEMS

75/22 WELCOME AND INTRODUCTIONS

Present

Denise Sterling **(DS)**	Non-Executive Director **(Chair)**
Ellen Armistead **(EA)**	Executive Director of Nursing
Dr David Birkenhead **(DBirk)**	Medical Director
Gina Choy **(GC)**	Public Elected Governor
Jo Fawcus **(JF)**	Chief Operational Officer
Karen Heaton **(KH)**	Non-Executive Director
Nicola Seanor **(NS)**	Associate Non-Executive Director
Kim Smith **(KS)**	Assistant Director for Quality and Safety
Elisabeth Street **(ES)**	Clinical Director of Pharmacy
Lucy Walker **(LW)**	Quality Manager for CCGs
Michelle Augustine **(MA)**	Governance Administrator **(Minutes)**

In attendance

Funmilayo Akinbodunse **(FA)**	Student Nurse on Placement **(observing)**
David Britton **(DBrit)**	Associate Director of Nursing – Medical Division **(item 80/22)**
Stacey Cartwright **(SC)**	Matron (**(item 80/22)**
Amanda McKie **(AMcK)**	Matron lead for learning disabilities **(item 81/22)**
Julie Mellor **(JM)**	Lead Nurse – Paediatrics **(item 80/22)**
Diane Tinker **(DT)**	Interim Head of Midwifery **(item 83/22)**

76/22 APOLOGIES

Lisa Cook **(LC)**	Head of Risk and Compliance
Jason Eddleston **(JE)**	Deputy Director of Workforce & Organisational Development
Jo Kitchen **(JK)**	Staff Elected Governor
Lindsay Rudge **(LR)**	Deputy Director of Nursing
Dr Cornelle Parker **(CP)**	Deputy Medical Director

77/22 DECLARATIONS OF INTEREST

There were no declarations of interest.

78/22 MINUTES OF THE LAST MEETING AND ACTION LOG

The minutes of the last meeting held on Wednesday, 20 April 2022 were approved as a correct record. The action log can be found at the end of these minutes.

79/22 MATTER ARISING: CQC INSPECTION PREPARATION PLAN

Ellen Armistead provided a verbal update on the CQC inspection preparation plan for undertaking an urgent and emergency care system review, which would entail the CQC attending the Emergency Department (ED) and possibly some acute medical ward areas. A process is in place to review compliance and standards to which CQC would hold us to account, with a daily meeting taking place, with good multidisciplinary representation. Last week, the CQC were on site for a planned visit to the ED and Ward 6 at HRI. The ED have been working through a process of putting in place an improvement plan, with evident, positive changes.

EA stated that the Trust has a good system in place for focused project management support, and the next steps will be to have continuous rounds of business as usual, compliance assessments. Meetings will take place both twice a week, and every day for preparation

around maternity services, and there will be six major work streams, data of which will be provided at the next Quality Committee on how the Trust will be prepared for CQC attending for a rated inspection.

The Committee conveyed thanks and appreciation to all colleagues who were involved with improvements in the ED, which were made in a very short space of time and under very difficult circumstances.

AD HOC REPORTS

80/22 SPLIT PAEDIATRIC SERVICE

David Britton, Julie Mellor and Stacey Cartwright were in attendance to present the above report, as circulated at appendix D, updating on work of the paediatric pathways on both the HRI and CRH sites; ongoing reconfiguration processes in relation to the paediatric pathways; the associated risks in both the Emergency Department and paediatrics, and the patient experience vision for children and young people.

In relation to risk 7776, **JM** reported that there is now an additional three whole time equivalent ACP's in training currently, one is in their first year, and two are nearing the end of their second year and will be qualified in September 2022. In relation to risk 7539, there are now four whole time equivalents, not 5.08 as stated in the report, which may also reduce the score of the risk. With regard to risk 6916, between the paediatric service, the surgical team and the ED team, a co-designed escalation process has been developed to escalate any time if there are concerns about a sick child. Risk 7872 will close once the children's Community Nursing Services move to Clock House in Elland, and the reconfiguration of that service is planned for Summer/Autumn 2022.

Next steps are to formalise the governance arrangements of the two services within medicine and children's services. There is a commitment from both teams, with a plan in place to meet to formalise the agenda. Given the risks and the significant mitigations in place, it is recognised that there is more work to be done to enhance the service for children and young people in the Emergency Department; and in line with the reconfiguration plan, there is a commitment for a single site, paediatric service as a whole.

EA asked about the model which should be in place for paediatric oversight of patients who are currently under the care of adult surgeons. **JM** stated that the escalation process, which is now in place, is that there is a paediatric consultant on call, available from the CRH site, that in the event that a child needed a clinical review from a paediatric point of view. In relation to oversight, **EA** stated that the electronic patient record is available, where the Paediatrician of the day should have some responsibility, and it was suggested that the original arrangements are revisited to confirm whether it was an escalation service or a proactive overview of patients that was required.
Action: That the original escalation process is revisited.

The Chair asked about the recommendation in the report relating to the consideration of whether the development of the paediatric ED requires executive sponsorship is required and dedicated project management support and put it to the Committee for any thoughts. **DBirk** stated that support from the Medical Directors' team will be provided.

KS suggested doing some quality improvement methodology with paediatrics and the ED, which will have external support and produce outcome measures. **KS** and **DBrit** agreed to meet to put together a proposal outside of the meeting.

DBrit commented on the good working relationship between Medical division and Families and Specialist Services (FSS) division colleagues who support each other really well, and conveyed thanks to colleagues in the FSS division.

OUTCOME: The Quality Committee noted the report.

81/22 LEARNING DISABILITIES MORTALITY REPORT

Amanda McKie was in attendance to present the above report, which will be circulated to the Committee after the meeting. The report highlights the Structured Judgement Reviews (SJRs) of deaths reported to the Learning Disability Morality review programme (LeDeR).

There were six deaths reported in quarters 1 and 2 of 2021/2022, and three of those deaths were serious incidents, which is an obvious deterioration. 66% of the SJRs noted very poor or poor quality of care, with some significant learning and issues. The average age of the deaths were 61 years of age. All six were white males with 67% mild/moderate learning disability. The deaths were in relation to:

- CPR being delayed due to confusion of status – this was a never event
- Application of principles of the Mental Capacity Act / Capacity assessments / best interest process
- A reliance on the specialist Matron lead for learning disabilities role
- Clinical ownership between the Emergency Department, the Acute Floor and the intensive support team
- Recognising the needs of people with learning disabilities and that outpatient investigations may not be in the persons best interests

Two patients' care were subject to a serious (red) investigation; one orange investigation was subsequently downgraded to a yellow investigation at surgical division level, and one orange investigation was also subsequently downgraded to yellow at medical division level.

The report was briefly summarised, which included data on the number of deaths, analysis on the age, level of learning disability and ethnicity of the patients, comments from the SJRs and the actions in place following the areas for consideration and discussion at the Mortality Surveillance Group.

EA asked which group is responsible for overseeing the actions in relation to improvements needed to be put in place, and whether there is clear governance. **AMcK** confirmed that this was the Care of the Acutely Ill Patient (CAIP) programme, and that further work is being done as the actions are wider than learning disabilities. **EA** stated that the matron lead for learning disabilities cannot be the only advocate for patients with learning disabilities and asked about other groups of colleagues. **AMcK** stated that work is ongoing with people with learning disabilities now on the situation report, which was a direct action from this; and the development of an inpatient Standard Operating Procedure, which is now being tested, and any escalation to be discussed at tactical meetings.

EA requested that a clear plan on a page of what action have been taken and will be taken in order to address this is brought back to the Quality Committee, to assure the Board that there is a governance structure and clear actions in place . It was also noted that medical teams and Allied Health Professional colleagues also need to be engaged, not only the nursing staff, as they will play a critical part in the care of these patients as well.

KS provided additional assurance on the serious incidents (SI), stating that rather than doing individual action plans and almost making the process more complicated, the serious incidents will be gathered by themes and trends which will be monitored by the SI panel, to ensure that there is no duplicate of effort. **KS** also stated that the work done by the SI panel will also be included in the action plan which is returned to the QC.

JF stated that support for this is available from divisional performance review meetings, and also suggested how this could be incorporated into divisional directors' appraisals

Action: AMcK to circulate report.
Action: Plan on a page to be provided at a later meeting, which will include the work of the SI panel.

82/22 MENTAL HEALTH STRATEGY

To be deferred.

SAFE

83/22 MATERNITY REPORT

Diane Tinker was in attendance to present the report at appendix G, highlighting the key points on:

- The final published Ockenden report, which identified 75 recommendations / actions for Maternity services. Following an initial RAG (red, amber, green) rating review of the standards, the Trust has 16 red actions and 38 amber actions, and a multidisciplinary action plan is being devised.
- The maternity services planned external support visit by the Regional Chief Midwife's team on 28 June 2022 to review progress with the seven immediate and essential actions from initial Ockenden report. Some targeted CQC meetings will start tomorrow, taking place twice weekly to concentrate on actions and see the position of the service for the visit.
- A letter received on 1 April 2022 asking Trusts to immediately assess the midwifery staffing position and make a decision about the continuation or suspension of Midwifery Continuity of Carer (MCoC). A paper was presented at Executive Board on 28 April 2022 outlining current position and recommendations, that we continue with two mixed risk locality-based teams in the highest areas of deprivation and suspend the delivery of care in labour and focus on increasing antenatal and postnatal continuity for a named midwife and buddy. This was agreed in principle at the Public Board, therefore will be aiming to implement the approved model from 20 June 2022.
- Year 4 of the NHS Maternity Resolution Scheme relaunch date is 6 May 2022, with a submission date of 5 January 2023. There have been some extended and new requirements which are being worked through.
- The service currently has five open and ongoing Healthcare Safety Investigation Branch investigations, and a resume of each case is included within the report.
- Maternity services submit workforce data to NHS England/Improvement each month and as of 25 April 2022, there was a recorded 162.55 whole time equivalent (WTE) (including 1 new appointments not in post) midwives against an establishment of 186 WTE midwives, however, with the approval of the continuity of carer new model, there should be a reallocation of staff in a place what can suit the acuity better. The service have also successfully offered four Band 6 midwives posts, and currently undergoing the regional recruitment for the newly qualified staffing, expected to join us in September 2022. Just put a bit of information there about Acuity and what we're looking for.

In relation to the relaunch of year 4 of the NHS Maternity Resolution Scheme, the Chair asked how confident the service were of achieving the requirements. **DT** stated that upon review, they should be able to be achieved, albeit with challenges, however, in the timeframe available, they will be able to be achieved.

The Chair also asked about the list of actions now required with the visit planned in June, and the amber and red actions. A number of actions are still linked to regional guidance or for a decision from the Local Maternity System. One of the red risks is linked to training which has not yet been developed and the Chair asked if we are in a position to get further guidance on those areas. **DT** stated that the service feel that the visit will concentrate on the seven initial actions from the first Ockenden report, however, they have not yet provided a steer on what needs to be done, therefore the service have benchmarked themselves. Other organisations will be having their visits imminently, and hopefully should receive some feedback from the Local Maternity System network on what they are focusing on.

OUTCOME: **DT** was thanked for the assurance update and the Committee noted the report.

CARING

84/22 ANNUAL PATIENT EXPERIENCE REPORT

To be deferred.

EFFECTIVE

85/22 MEDICAL EXAMINER UPDATE

To be deferred.

RESPONSIVE

86/22 INTEGRATED PERFORMANCE REPORT

Jo Fawcus presented the integrated performance report at appendix J, highlighting key points.

Trust performance for March 2022 was 64%. The **SAFE** domain is now amber following a never event in March. The **CARING** domain remains amber with two of the five Friends and Family Test areas now green but maintaining performance in Complaints is still a challenge. Dementia screening has improved slightly to 25%. **EFFECTIVE** domain remains amber as Hospital Standardised Mortality Ratio has risen above 100. Fractured Neck of Femur is still a challenge at 64%. The **RESPONSIVE** domain remains amber with all key cancer targets achieved for March which is an excellent achievement. Stroke indicators alongside the underperformance in the main planned access indicators and the Emergency Department remains a challenge moving forward. **WORKFORCE** remains amber and there is a peak in the 12-month running total for both long-term and short-term sickness with an increase in Covid-related sickness in March when compared to February, though not at the same level as seen in January. Return to Work Interviews have improved in month. **FINANCE** domain remains amber whilst Use of Resources indicator has returned to green.

In relation to recovery, one of the tasks at the moment is that 104-week patients are treated by July 2022, which the Trust is currently on track to achieving. There are still significant issues around some diagnostic modalities, in particular MRI which is on a trajectory to clear the backlog and there are issues remaining in our echo and neurophysiology diagnostic services.

The Chair asked Stroke capacity and how that has improved. **JF** stated that following the stroke summit in March 2022, our key partners have been working very closely with the discharge team and doing some significant detailed work on the stroke wards. It has now been realised, going forward, that different types of stroke services in the community will need to be commissioned to support stroke patients. It was also noted that during last week, the transfer of care numbers reduced down to 64, which remained consistently around 110 throughout winter. This has demonstrated a real improvement in how teams are working together.

OUTCOME: **JF** was thanked for the update and the Quality Committee noted the report.

ITEMS TO RECEIVE AND NOTE

87/22 CLINICAL OUTCOMES GROUP MINUTES

A copy of the Clinical Outcomes Group minutes was available at appendix K for information.

GC asked about the plan for dementia going forward, and whether there was any further progress with dementia screening. **DBirk** stated that work is ongoing with dementia screening, including trying to find ways of making it visible on the Electronic Patient Record (EPR) when dementia screens have not taken place and therefore need to be actioned. Work

is ongoing around whiteboards and making EPR more transparent, however, there are some issues in relation to data accuracy and quality which need to be addressed. There are ways which dementia screens can be forced to be done, however, they are not without risk. One of them is to have a full stop on the system, making it difficult to progress past a screen which asks for the screen to be completed. Another way is to require that dementia screens and other mandatory screens are completed before patients move wards, but this potentially places some risks in relation to flow. There is more work ongoing around whether the data reported and automatically generated from EPR represents a true picture, as there is a view from colleagues that dementia screens are being carried out but not recorded in the section of EPR whereby they are picked up automatically. There is a manual audit ongoing for some evidence.

The Chair noted the discussion on sepsis from the minutes and a comment on the sepsis trajectory being stalled and asked if there were any actions going forward on in terms of the key issues. **DBirk** stated that there is a sepsis working group which sits outside of the Clinical Outcomes Group, and reports into the Care of the Acutely Ill Patient (CAIP) programme, which is focusing its work on the Emergency Department, with an action plan and a trajectory to improve. The key is that it is not just the Emergency Department but deteriorating patients in the acute admission wards also.

In relation to the quality priority for Sepsis, **KS** commented on three specific quality indicators which will be managed via the Knowledge Portal, and will be submitted to the Quality Committee, along with the quality indicators for all quality priorities with more oversight and scrutiny of performance.

OUTCOME: The Committee received and noted the minutes.

88/22 ANY OTHER BUSINESS

The Chair reminded Committee members about the circulated draft copy of the Quality Accounts for comments, which are expected by Thursday, 19 May 2022.

89/22 MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS

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

- An update on the split paediatric service, the work being done and what is going forward
- The learning disability mortality report, with an action plan returning to the Quality Committee at a later date
- The maternity report and the approved model of working for midwives which will be implemented on 20 June 2022.
- The Integrated Performance Report, and the achieved cancer targets in April 2022, and the improvement in stroke capacity and the reduced transfer of care figures.

90/22 QUALITY COMMITTEE ANNUAL WORK PLAN

The workplan was available at appendix L for information.

POST MEETING REVIEW

91/22 REVIEW OF MEETING

- *Could do better*…….if reports were submitted on time, which then impacts on heavy agendas in subsequent months. **NS** stated that this is a similar picture from the Patient Experience Group with challenges with feedback and representation.
- *What went well*……. everyone working well together.

NEXT MEETING

Monday, 20 June 2022 - 3:00 – 4:30 pm - Microsoft Teams

Calderdale and Huddersfield NHS Foundation Trust

QUALITY COMMITTEE ACTION LOG

Following meeting on Monday, 16 May 2022

Overdue	New / Ongoing	Closed	Going Forward

MEETING DATE AND REF	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	RAG RATING
NEW / ONGOING ACTIONS				
16.05.22 (80/22)	**Split Paediatric Service**	**Julie Mellor**	**Action 16 May 2022**: That the original escalation process is revisited. **Update**: Awaiting response from Julie Mellor as to when this will be available for the Quality Committee	**ONGOING**
UPCOMING ACTIONS				
16.05.22 (80/22)	**Learning Disabilities Mortality Report**	**Amanda McKie**	**Action 16 May 2022:** Plan on a page to be provided at a later meeting, which will include the work of the SI panel. **Update**: Amanda McKie to take to Mortality Surveillance Group for sign-off on 24 June 2022	**DUE Monday, 18 July 2022**
21.02.22 (23/22) 20.04.22 (60/22)	**Deteriorating patient case note review**	**Risk Team**	A formal report on the issue of deteriorating patients was asked into Quality Committee for April 2022. **ACTION**: Report requested for Quality Committee in April 2022. **Update 20 April 2022**: See agenda item 60/22. **ACTION - 20 April 2022**: Update on case note review requested for three months' time ***(Added to workplan to return to Quality Committee in August 2022)***	**DUE Monday, 17 August 2022**
CLOSED ACTIONS				
20.04.22 (66/22)	**Committee Self-assessment**	**All**	**ACTION - 20 April 2022**: Self-assessment forms to be circulated on Friday, 22 April 2022, with a response requested by Friday, 6 May 2022.	**CLOSED Friday, 6 May 2022**
20.04.22 (71/22)	**CQC Preparation**	**Ellen Armistead**	**ACTION – 20 April 2022**: **EA** to provide an update on CQC preparation and expectations of the organisation. **Update 16 May 2022**: See item 79/22	**CLOSED Monday, 16 May 2022**
16.05.22 (80/22)	**Learning Disabilities Mortality Report**	**Amanda McKie**	**Action 16 May 2022: AMcK** to circulate report - **COMPLETED**	**CLOSED**

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE COMMITTEE

Held on Tuesday 12 April 2022, 3.00pm – 5.00pm
VIA TEAMS

PRESENT:

Ellen Armistead	(EA)	Chief Nurse
Peter Bamber	(PB)	Governor
David Birkenhead	(DB)	Medical Director
Suzanne Dunkley	(SD)	Director of Workforce and Organisational Development
Karen Heaton	(KH)	Non-Executive Director (Chair)
Jason Eddleston	(JE)	Deputy Director of Workforce and Organisational Development
Helen Senior	(HS)	Staff Side Chair
Denise Sterling	(DS)	Non-Executive Director

IN ATTENDANCE:

Carys Bentley	(CB)	Colleague Engagement Advisor (for item 28/22)
Alison Bohannon	(AB)	Workforce Business Intelligence Officer (for item 25/22)
Brendan Brown/Tahliah Kelly-Martin	BB/TKM	BAME Network Update
Andrea Dauris	(AD)	Associate Director of Nursing (Corporate) (for items 30/22 and 31/22)
Nikki Hosty	(NH)	Assistant Director of HR (for item 2722)
Jackie Robinson	(JR)	Assistant Director of HR (for item 26/22)
Emma Short	(ES)	HR Advisor

20/22 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting.

21/22 **APOLOGIES FOR ABSENCE**

Andrea McCourt, Company Secretary
Mark Busby, Workforce Business Intelligence Manager

22/22 **DECLARATION OF INTERESTS**

There were no declarations of interest.

23/22 **MINUTES OF MEETING HELD ON 15 FEBRUARY 2022**

The minutes of the Workforce Committee held on 15 February 2022 were approved as a correct record.

24/22 **ACTION LOG – April 2022**

The action log, as at 15 February 2022, was received.

25/22 **QUALITY AND PERFORMANCE REPORT (WORKFORCE) – MARCH 2022**

AB presented the report.

Summary

Performance on workforce metrics is now amber and the Workforce domain has remains at 52.2% in February 2022. This has remained in the amber position for an eighth month. 6 of the 15 current metrics that make up the Workforce domain score are not achieving target – 'Return to Work interviews recorded', short Term Sickness Absence rate (rolling 12 moths) and 'Sickness Absence Rate (rolling 12 month)' and 'Long term sickness absence rate (rolling 12 month)', and Data Security Awareness EST compliance as well as Fire Safety EST compliance. Medical appraisals are currently not included in the overall Domain score due to the current Covid-19 pandemic, and Non-medical are not included as the appraisal season is extended to March 2022

Workforce – February 2022

The Staff in Post has decreased to 6146, which, is due, in part to 25.46 FTE leavers in February 2022. FTE in the Establishment figure increased by 27.50, along with student nurses leaving.

Turnover increased to 7.90% for the rolling 12-month period March 2021 to February 2022. This is a slight increase on the figure of 7.83% for January 2021.

Sickness absence – February 2021

The in-month sickness absence decreased to 6.08% in February 2022. The rolling 12-month rate also increased for the twenty ninth consecutive time in 39 months, to 5.45%. Anxiety, Stress and Depression was the highest reason for sickness absence, accounting for 26.57% of sickness absence in February 2022, with Chest and Respiratory problems the second at 22.43% in February 2022.

The RTW completion rate decrease to 60.67% in February, down from 62.05% in January 2021. This is the seventh consecutive month under 65%.

Essential Safety Training – February 2022

Performance has increased in 5 of the core suite of essential safety training. With 7 out of 10 above the 90% target however only 1 achieving the 95% 'stretch' target. Data security awareness target has been amended to fall in line with national guidelines and is now 95%. Overall compliance increased to 92.57% and is the first increase following last month's decrease. It is however no longer above the stretch target of 95.00%.

Workforce Spend – February 2022

Agency spend increased to £0.91M, whilst bank spend decreased by £0.48M to £3.42M.

Recruitment – February 2022

All of the 5 recruitment metrics reported (Interview to conditional offer, and Pre employment to unconditional offer) increased in February 2022. The time for Unconditional offer to Acceptance in January 2022 improved and was 0.5 days.

DS asked how the new portal can assist with RTW interviews. ES explained the RTW recording process has been streamlined with the portal designed to provide e-prompts to managers once they have recorded the absence on ESR. The portal has direct e-links to ESR/e-roster. ES reported positive feedback has been received from managers, HS reinforced the great feedback adding it's a brilliant system.

PB queried why the report omitted to show a breakdown of data by department. SD advised there is an established monthly workforce monitoring meeting which undertakes the deeper analysis. JR confirmed the integrated performance report is produced on a divisional level and is communicated by the HR BPs into divisional senior management teams for divisional discussion.

KH was pleased to hear about the enhanced RTW recording system. KH noted the increase in new starters in some areas and asked about the gap between starting date and undertaking corporate induction. SD reported the aim is to take in new staters every 2 weeks to coincide with fortnightly induction dates. JR advised during the pandemic a more flexible approach to start dates has been adopted which has resulted in the coordination of the onboarding and engagement more challenging. The approach is being closely monitored.

SD reported following discussions with the performance team it has been agreed from 1 April 2022 to stretch the sickness absence target to 4.75% for non-covid absence (5.75% including covid).

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

26/22 **RECRUITMENT STRATEGY**

JR presented the 2022/2025 recruitment strategy.

The strategy described the goal 'To recruit, develop and retain an outstanding workforce which delivers one culture of care to each of our patients and makes CHFT an employer of choice for our local communities'. The strategy has an overarching four key themes; Attraction and Recruitment, Developing our Workforce, Widening Participation, and Why we are CHuFT to be CHFT. The strategy outlined specific themes and activities underpinning the four key themes. An action plan will be developed to support the strategy. The strategy will be shared more widely and be embedded as part of the strategic recruitment work and through the recruitment microsite.

KH felt this is a good, clear strategy and looks forward to seeing the action plan.

EA liked the format, adding that the strategy should be more explicit in regard to becoming an Anchor Institution and also suggested tweaking the wording to read 'a Workforce reflective of our local communities'. JR thanked the Committee for its feedback and will amend the strategy accordingly. An update will be presented to the Committee in 6 months' time.

OUTCOME: The Committee **NOTED** the Recruitment Strategy.

27/22 **DEVELOPMENT FOR ALL**

NH presented the new interactive OD development for all brochure, an e-magazine which all colleagues can access via their Trust email account. The approach fosters one culture of care, focusing on change and improvement, wellbeing, inclusion and engagement. CHFT aims to implement an inclusive workforce development approach, centred on leadership, personalised learning, networks, experiential learning and unlocking the talent of our people. Everything we deliver will align to the overall NHS People Promise.

OUTCOME: The Committee **NOTED** the Development for All offer.

28/22 **COLLEAGUE ENGAGEMENT PLAN**

CB presented the 2022 engagement, inclusion and Health & Wellbeing calendar. Successful activities already taken place this year include LGBT+ history month, International womens day and elimination of racial discrimination – root out racism pledge. Other events to come include a Wellbeing event, A day to be CHuFT and the CHuFT Awards. The calendar brings together engagement, inclusion, wellbeing and development. Events will focus on outcomes of the staff survey to continue to encourage colleagues to use their voice.

OUTCOME: The Committee **NOTED** the Colleague Engagement Plan.

29/22 **TEAM ENGAGEMENT AND DEVELOPMENT (TED)**

PG presented an overview of TED, a team engagement approach to a diagnostic survey exploring 8 dimensions. It allows structured engagement discussions, offering a toolkit of resources with measurable outcomes. It emphasises the impact of teams on care, and highlights benefits throughout different levels, benefitting the team, team leader and the organisation. The framework underpins one culture of care and gives colleagues a voice to be part of a team.

JE asked about the teams taking part in the first tranche. PG reported CHFT is one of the first organisations trialling TED. The first cohort of eight teams comprised pharmacy, nursing and corporate teams.

DS asked how the development will be fed back in across the organisation. PG confirmed there is a level of anonymity to encourage honesty. The diagnostic tool facilitates at an organisational level the tracking of trends at the start and finish of the process.

The Committee recognised the excellent work in defining the new approaches - Development for All, Colleague Engagement Plan and TED. KH looked forward to future updates and extended an invitation to hear from colleagues who had taken part.

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

30/22 **NURSING WORKFORCE PROGRAMME UPDATE**

AD presented an overview on the schemes to establish safe and effective nursing and midwifery staffing. The strategies are coordinated through the Nursing and Midwifery Steering Group. The key points to note were:

- Use of Business Intelligence Data to inform recruitment
- The development and implementation of the Enhanced Dashboard Metric
- Successful International Recruitment Campaign
- Ongoing Recruitment to Apprentice Nursing Associate programme
- Ongoing Recruitment to Apprentice RN programme
- Enabling an Effective Learning Environment (EELE) and Clinical Placements Expansion (CPEP) programmes
- HCSW Recruitment Programme
- Effective E-Rostering

KH commended the positive statements in particular the work towards a nationally recognised pastoral quality award. DS praised the international recruitment and noted the low attrition rate.

DS was interested to know more about the work to expand the student experience across other professions and highlighted that all areas should be involved in providing learning to enhance the student experience. AD confirmed a number of opportunities exist currently and added this is a piece of work being undertaken by the Education Committee. JE concluded the Education Committee's governance framework is designed to ensure students have a voice to inform the Trust's offer to future student cohorts. The Workforce Committee would be updated as the work progresses.

DS noted the fantastic target for the number of vacancies for the next year and asked in terms of the over 50s workforce what the expected vacancy position is looking like for the coming years. JE confirmed a piece of work looking at age profile activity is currently being undertaken and a paper will be presented at the next Workforce Committee meeting.

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

31/22 **DEVELOPING WORKFORCE SAFEGUARDS**

AD presented an update on the progress against the 14 key recommendations as set out in the Developing Workforce Safeguards (2018). The key points to note were:-

- Of the 14 recommendations within the Developing workforce safeguards (2018) document the Trust is compliant with 9 recommendations, and partially compliant with 5 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.

AD felt from a CQC perspective there is assurance the Trust's could describe clearly its position against this document and its position on how we progress going forward.

An update will be provided at a future Committee meeting.

OUTCOME: The Committee **APPROVED** the updated position and **NOTED** the assessment against the 14 recommendations, including the revised action plan.

32/22 **ENHANCED SUPPORT TO COLLEAGUES**

SD reported that as the NHS is facing continued challenges due to COVID, backlogs and colleague availability, some incentives that were previously dismissed need to be revisited. SD presented to the Workforce Committee for discussion and consideration 2 incentives:

- Buy back of annual leave
- Pensions recycling

Following discussion, the Committee agreed there are some merits to both incentives however there was real concern regarding the implications both incentives could have for some colleagues. HS would gain views from staff side colleagues and report back. SD thanked Committee members for their views. Annual leave would be discussed further at Executive Board. Further research is being undertaken regarding pensions recycling before being further discussed at Executive Board. Both incentives will be presented for discussion at a future Board of Directors meeting.

OUTCOME: The Committee **COMMENTED** on the incentives.

33/22 **WEST YORKSHIRE AND HARROGATE (WY&H) PEOPLE PLAN**

SD provided an overview of the main focus of the WY&H People Plan and how the publication of the plan will impact CHFT. The Plan has a clear focus which is more staff working differently in a compassionate culture. A new People Director, Kate Sims, will be responsible for ensuring all sectors work together to deliver the actions set out in the plan and in the timescales agreed. The Plan brings together work in all health and social care sectors – local authorities (LAs), universities and colleges, NHS trusts including mental health and community.

SD confirmed a refresh and refocus on CHFT's People Strategy is underway with alignment to the WY&H People Plan and NHS People Promise. CHFT will focus on increasing our work on working with carers, work more closely with our LAs, Locala, GPs and further development of the Workforce Design section of our People Strategy. Aligned with our staff survey action plan, the refreshed Strategy will take a 'bottom up' approach. The refreshed Strategy will be

presented to the Board of Directors. The Committee agreed this was appropriate timing and looked forward to seeing the refreshed CHFT People Strategy.

OUTCOME: The Committee **NOTED** the main aspects of the WY&H People Plan.

34/22 **BOARD ASSURANCE FRAMEWORK – RISK 10b/19 NURSE STAFFING**

EA presented a deep dive into BAF risk 10b Nurse Staffing. EA confirmed the risk remains relevant and is reflective of the current position. A review of existing key controls has strengthened arrangements for triangulation of the impact of staffing availability on patient experience and nurse sensitive key performance indicators. Senior nurse staffing meetings remain in place. Further key controls include the development of staffing Opel action cards and introduction of quality and oversight meetings which have received positive feedback from senior nurses. In terms of Positive Assurances, the vacancy position is significantly improved and the Hard Truths process was completed in March 2022. EA advised Gaps in Control relate to management of covid numbers, increase in non-elective activity and staff sickness. The level of risk remains unchanged and the Committee noted the Quality Committee will also examine any gaps in control and assurance.

OUTCOME: The Committee **NOTED** the updated BAF.

35/22 **UPDATE FROM BAME CHAIR**

BB/TKM presented an overview of the Network which included:-

- Network aims
- Reflections of 2021
- Objectives for 2022
- Challenges and opportunities
- Looking to rename the group

The presentation outlined how the Workforce Committee can support the network:-

- Senior level conversations to raise awareness
- Encourage more involvement of more managers
- Supporting release from duty for colleagues

SD stated Cultural Awareness would be really well received and would welcome a conversation on how to take this forward. DS felt the presentation covered very well where priorities need to be and agreed that it is important to have safe spaces for cultural awareness conversations to take place. DS underscored the points made that the Trust is committed to calling out zero tolerance to inappropriate behaviour. DS referenced the lack of progression opportunities and highlighted the importance of constructive feedback.

JE remarked on the calling out of poor behaviour and would certainly welcome this in order to route it out. JE commended the presentation and highlighted the importance of receiving regular updates from each of the Network groups and the opportunity it gives the Workforce Committee to help and support. DS echoed this stating we need to communicate the benefits the Networks bring to the Trust. KH reinforced there is an open door into Workforce Committee for all the Network Committees.

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

36/22 **UPDATE FROM EDUCATION COMMITTEE**

The notes of the Education Committee had been shared with the Workforce Committee. JE highlighted the following pieces of work:-

- 6 priorities for next 12 months have been established
- A data dashboard to be developed
- Use of simulation suites on both sites
- Immediate work required on EST compliance

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

37/22 **WORKFORCE COMMITTEE WORKPLAN**

The workplan was received and reviewed.

38/22 **ANY OTHER BUSINESS**

The Workforce Committee Self-Assessment would be circulated to members for completion. The Workforce Committee Annual Report would be presented at the June Committee meeting.

39/22 **MATTERS FOR ESCALATION TO THE BOARD OF DIRECTORS**

Recruitment Strategy
Workforce Report
Reflections BAME network
BAF – Nurse Staffing
People Strategy Refresh

40/22 **EVALUATION OF MEETING**

No comments were given.

41/22 **DATE AND TIME OF NEXT MEETING:**

Hot House: 29 April 2022, 2pm-4pm The CHFT colleague journey (building in our 2021 staff survey feedback)

Committee Meeting: 6 June 2022, 3pm – 5pm